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ABSTRACT

Five issues of the bulletin "Zero To Three" are collected here. The first issue features a discussion by T. Berry Brazelton of assessment as a method for enhancing infant development. The second excerpts materials from Stanley I. Greenspan's book "Psychopathology and Adaptation in Infancy and Early Childhood." The excerpt describes phase-specific disorders of infants 12 through 18 months of age, offers guidelines for therapeutic intervention, and presents a clinical illustration taken from the same book. The third bulletin of the series reports on the second training institute of the National Center for Clinical Infant Programs, which focused on the first 18 months of infant development. The fourth issue discusses maternal and child health nursing with regard to service, research, and training. The fifth publication in the series describes facet theory, an approach to research in child development and child psychiatry. Other articles in the series (1) describe attempts to reduce the incidence of child maltreatment and to describe paraverbal therapy with adolescent mothers and their children, (2) discuss training the pediatrician in the psychosocial aspects of child health, and (3) present case reports of two parents' voluntary relinquishment of their child and an intervention designed to remove obstacles to attachment between an adolescent mother and her baby. (RH)

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Zero to Three

Bulletin of the
NATIONAL CENTER FOR CLINICAL INFANT PROGRAMS VOL. II, NO. 1 SEPTEMBER 1981

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ASSESSMENT AS A METHOD FOR ENHANCING INFANT DEVELOPMENT

by T. Berry Brazelton, M.D.

A portion of this paper was presented at the First World Congress on Infant Psychiatry, sponsored by the International Child Psychiatry Association at Cascais, Portugal, April, 1980.

The work cited has been done in conjunction with Heidelise Als, Barry Lester, Edward Tronick, Michael Yogman, Kate Neff, Maggie Moore-Calloway, Joan Gilman, Emily Burrows, Ann Berger, Sylvia Howe, Anna Lombroso, Carey Halsey, and Nancy Kozak. To each of them belongs the credit for the incisive use of each of the instruments and the results. The parents who participated shared generously in all of our endeavors.

The Brazelton Neonatal Behavioral Assessment Scale (1) was designed as a clinical instrument for use with parents and newborn infants. It has the advantages and disadvantages of a clinical assessment. Not only was it conceptualized from my experiences as an "interactive pediatrician"—interactive with both the infant and the parents—but it was an attempt to see the interaction within the infant of the demands of his[*] immature physiological systems and his attempts to organize them *in order* to interact with his environment.

In the early 1950's, I was stunned and exhilarated to recognize that in order to attend to and respond to social stimuli a newborn, even under stress, would make massive attempts to control interfering motor activity and cardiorespiratory demands. As he emerges from sleep and goes on to crying, the infant uses a series of maneuvers to maintain an alert "state" of consciousness. He first turns his head to one side, setting off a tonic neck reflex. Second, he tries to overcome this by completing a hand-to-mouth maneuver. When this is completed, he will root and suck on the fingers which are next to his mouth. This is followed by a sigh, and, with a brightening look, the baby will survey the close environment with his eyes as he attends to it with his ears. In other words, the newborn used a series of reflex responses in an organized attempt to master motor activity in order to listen and to look. One only needs to see this active attempt to master himself in order to realize that the newborn infant is an active, eager interactant with the world around him.

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[*] For simplicity's sake, I shall use the masculine pronoun for the infant and the feminine pronoun for the parent. Although this probably represents a kind of bias, it does avoid the disturbing his/her combination for the reader. I apologize in advance for the biases this represents.

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INTRAUTERINE EXPERIENCE

Since developing the scale I have become aware of how significantly his interauterine experience has already shaped a newborn's behavior. No longer can we conceptualize behavior at birth as genotypic; we must consider it phenotypic. The infant's genetic potential has been shaped for nine months by the rhythms of the uterus and the metabolic, neuromotor, and neuroendocrine envelope in which his mother nurtures him in pregnancy. For we know now that nutrition, infection, drugs, and psychological experiences of the mother are indeed transmitted to her fetus and affect his developmental potential and his behavior. He responds through her but he also responds directly—for he can and does see, hear, and respond to kinesic and vestibular experiences. In fact, he responds differently to quantitatively different events and even shuts them out when he can no longer "afford" to respond. So the shaping of his behavior has had a long and important history—both genetic and epigenetic in etiology—by the time of birth. The interaction between nature and nurture has already become intractably intertwined and is illustrated in Figure 1 (2).

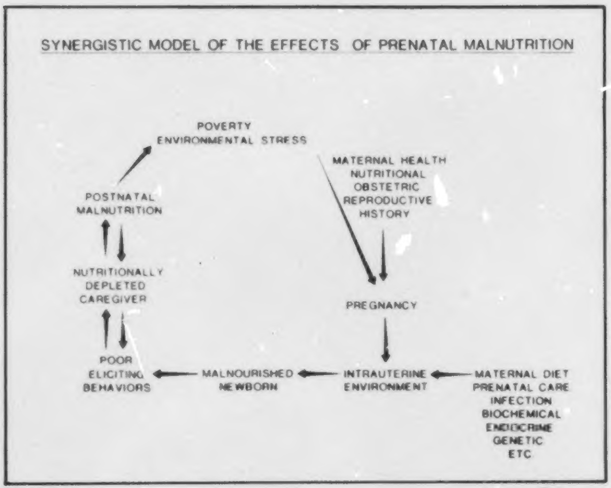

Figure 1

Looking at the neonate, we can make a kind of postdictive assessment of intrauterine conditions and of intrauterine experience. The neonate's unresponsive social behavior in a chronically undernourished group in Guatemala (3) correlated with the degree of maternal under-nutrition and of reduced maternal height and with her increased morbidity around delivery. We felt this demonstrated the two-generational effect of the degree of chronic undernutrition which had affected the mother in her own mother's uterus. This was reflected in the neonate's behavioral responsiveness, and, of course, predicted to his future outcome (3).

The undernourished mother of a poorly responsive neonate will respond to him in ways counterproductive for his recovery. She is likely to feed him "on demand" (three times per day in the neonatal period) and to "leave him alone" when he provides her with inadequate feedback. He can not tell her that he needs more, not less, stimulation in order to recover.

Within a group of severely undernourished Guatemalan neonates, we could predict with a very high degree of accuracy (.85-.9) which neonate would be selected for marasmus in the first year or kwashiorkor a year later. His neonatal behaviors—slow, too-quiet state changes, long latencies to responses, poor quality of interactive behaviors, autonomic instability—all predicted. Since the mothers were also inadequately nourished, overloaded with too many children, they could feed and stimulate their babies only inadequately in the first few months of life. Of course, we could identify at birth those children selected for low I.Q.'s and poor later development. The stage is set.

I've been told that seventy-five per cent of a million "retarded" children (I.Q.'s under 80) in Caracas, Venezuela are socially undernourished and only apparently

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retarded, hence are redeemable. If nutrition and stimulation could be provided early to these undernourished children of poverty, they might adapt better to early stresses of weaning, infection, and parasites and to school later on.

CHANGES IN ASSESSMENT SCALE PERFORMANCE

The dynamic model of the organization of neonatal behavior that underlies the conceptualization of the Brazelton scale assumes considerable change in scale performance during the neonatal period. For one thing, we see the examination itself as part of the infant-caregiver interactive system. Many of the changes in neonatal behavior are due to the reciprocal feedback system between the infant and the caregiving environment.

This recognition of the importance of the effects of the caregiving environment is recent and came from accumulating evidence from longitudinal studies which showed disappointing relationships between early infant behaviors, events associated with early infancy and later developmental outcome (4,5). As a result, we now look for continuities in development in the infant as part of the infant-caregiver system, rather than treating infant behavior as an isolated entity. We expect developmental prediction to come from the study of the processes of biobehavioral organization, based on a transactional view in which development proceeds as infant and caregiver continually modify their own and each other's behavior through reciprocal interaction.

Table 1: Neonatal Behavioral Assessment

The behavioral items are:

1. Response decrement to repeated visual stimuli
2. Response decrement to rattle
3. Response decrement to bell
4. Response decrement to pinprick
5. Orienting response to inanimate visual stimuli
6. Orienting response to inanimate auditory stimuli
7. Orienting response to animate visual—examiner's face
8. Orienting response to animate auditory—examiner's voice
9. Orienting responses to animate visual and auditory stimuli
10. Quality and duration of alert periods
11. General muscle tone in resting and in response to being handled (passive and active)
12. Motor maturity
13. Traction responses as he is pulled to sit
14. Cuddliness—responses to being cuddled by the examiner
15. Defensive movements—reactions to a cloth over his face
16. Consolability with intervention by examiner
17. Peak of excitement and his capacity to control himself
18. Rapidity of buildup to crying state
19. Irritability during the exam
20. General assessment of kind and degree of activity
21. Tremulousness
22. Amount of startling
23. Lability of skin color (measuring autonomic lability)
24. Lability of states during entire exam
25. Self-quieting activity—attempts to console self and control state
26. Hand to mouth activity

Table 2: Elicited Responses

	O*	L	M	H	A†
Plantar grasp		1	2	3	
Hand grasp		1	2	3	
Ankle clonus		1	2	3	
Babinski		1	2	3	
Standing		1	2	3	
Automatic walking		1	2	3	
Placing		1	2	3	
Incurvation		1	2	3	
Crawling		1	2	3	
Glabella		1	2	3	
Tonic deviation of head and eyes		1	2	3	
Nystagmus		1	2	3	
Tonic neck reflex		1	2	3	
Moro		1	2	3	
Rooting (intensity)		1	2	3	
Sucking (intensity)		1	2	3	
Passive movement					
Arms R		1	2	3	
L		1	2	3	
Legs R		1	2	3	
L		1	2	3	

*O response not elicited (omitted)
†A asymmetry

We *expect* and value change in the Brazelton scale during the neonatal period, seeing this change as evidence of the neonate's own recovery and his response to his new environment. The behaviors which are the most basic to the newborn's physiological organization (e.g., habituation, autonomic regulation and motor performance) may be least affected over time. On the other hand, the more interactive behaviors, such as orientation, use or range of states, consolability, may change the most. By plotting the neonate's patterns of performance over the course of a series of examinations, we can assess the baby's recovery from the immediate stress of labor and delivery and the adaption to the postnatal caregiving environment.

Repeated assessments measure the adaptive and coping strategies and capacities of the neonate or the neonate's organizational adjustments to the demands of a new environment. Our goal is to study these patterns of performance over repeated assessments as measures of organizational shifts in underlying processes. These organizational process or recovery curves may predict to the future coping capacities of the infant. Rather than predict from a single assessment, we expect to find the maximum predictive validity of the scale in the organizational processes captured by the descriptive parameters, such as the shape or function of these curves. From these features we hope to identify patterns of individual differences, the infant's organizational "signature," that will discriminate among normal infants and help identify the infant at risk (2).

THE INFANT AT RISK

As the potential for early intervention increases, we need to evaluate at-risk infants as early as possible with an eye to more sophisticated preventive and therapeutic approaches. Early intervention may prevent that compounding of problems which occurs all too easily when the environment cannot adjust appropriately to the infant at risk. Premature and minimally brain-damaged infants seem to be less able to compensate in disorganized, depriving environments than well-equipped neonates, and their problems of organization in development are compounded early (8).

As noted above, quiet, nondemanding infants do not elicit necessary mothering from already overstressed parents and are selected by their neonatal behavior for kwashiorkor and marasmus in poverty-ridden cultures such as are found in Guatemala and Mexico (9, 10). Hyperkinetic, hypersensitive neonates, on the other hand, may press a mother and father into a kind of desperation. This produces child-rearing responses from them that reinforce the problems of the child, so that he grows up in an overreactive, hostile environment (11).

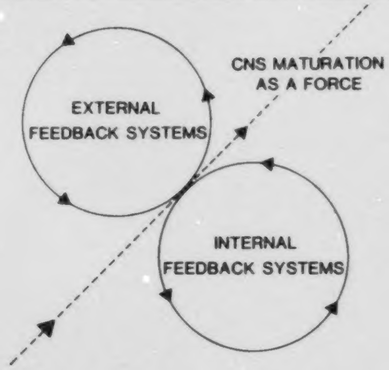
Parents of children admitted to the wards of the Children's Hospital in Boston for clinical syndromes such as failure to thrive, child abuse, repeated accidents and ingestions, and infantile autism are often successful parents of other children. They associate their failure with the one child to an inability to "understand" him from the neonatal period onward, and they claim a difference from the other children in his earliest reactions to them. Assessment of risk in early infancy could mobilize preventive efforts and programs for intervention before the neonate's problems are compounded by an environment which cannot understand him without such help. Minimally brain-damaged babies do make remarkable compensatory recoveries in a fostering environment. By understanding the infant and the problems he will present to his parents, we professionals may provide more support for them as they adjust to a difficult infant.

THEORETICAL BASE

Implicit in the concept of developmental assessment must be a theoretical base for understanding an infant's development. In my own work, I have formulated such a base, which includes three sources of energy for development.

As shown in Figure 2, the central nervous system (CNS) matures in a healthy organism at an expected rate. This maturation forces the developing infant to go on from each new level of achievement to the next. Any achieved level of homeostasis is shaken and a new one needs to be reached.

What provides the necessary energy for the progress necessary to achieve each new level? Sources from within the baby himself and from the environment fuel this developmental progress.


CNS MATURATION AS A FORCE
EXTERNAL FEEDBACK SYSTEMS
INTERNAL FEEDBACK SYSTEMS

THREE SOURCES OF ENERGY FOR DEVELOPMENT

Figure 2

As the baby works to achieve a goal, his behavior illustrates his struggle. As he learns to walk, for example, the infant spends all day practicing various aspects of walking—getting up on his feet and down again, cruising from one piece of furniture to another, standing alone but not daring quite to step out alone. All of his energies go into this—he cannot sleep, he eats poorly, he cries when his parents leave the room or turn their backs on him. Every other kind of learning waits while he learns the new, important skill of walking. When the infant finally makes it and can take steps alone, the joy on his face expresses the excitement he feels at having completed the feedback cycle of expectancy toward that goal. His sense of achievement fuels him for the next step.

Robert White (11) labels this inner excitement a "sense of competence."

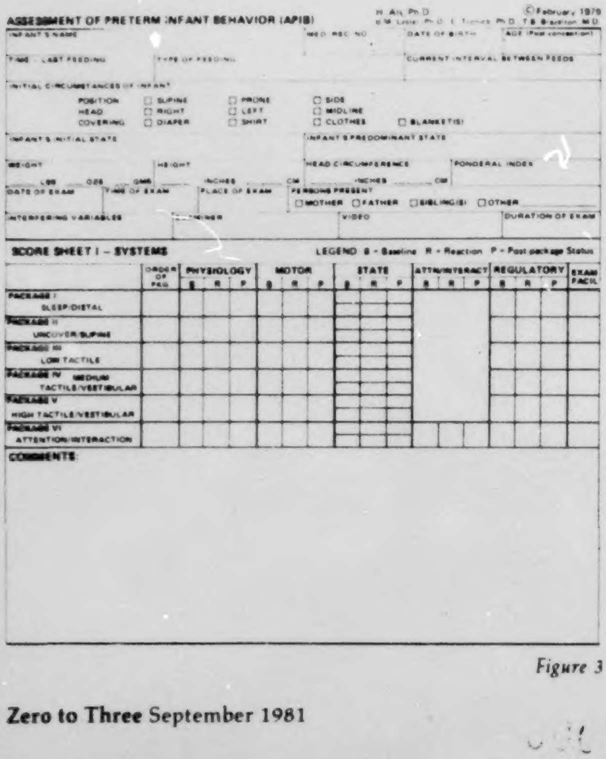
The environment offers a second major source of reinforcement, of fuel or energy for this maturational process. As a baby vocalizes, for example, the mother vocalizes back to him. When he says "ooh," she says "oh yes!" After his repeated "ooh," she says "oh, what?" or "oh, come on." With her repetition of his vowel sound, she has rewarded him for his utterance, but she has also couched it in an adult word. Not only has she said, "You did it!" but she says, "Come on, there's more to go!" Through this process she leads him on as well as applauding him for what he has done. These two sources of fuel energize the child to make the necessary progress from one stage to the next.

WHAT SHOULD AN EVALUATION OF INFANTS INCLUDE?

Evaluations must take into account these three sources of energy for development. Since they are operant in the uterus, as well as at birth, they form the theoretical basis for an optimal evaluation of the neonate, whose prenatal experiences have both been incorporated into a developing brain and have been fueling the development of this brain. The assessments should account for all three components—CNS maturation, inner feedback systems, and external experiential reinforcement.

We have been interested in developing a process-oriented assessment for high-risk and premature infants. We are aware that the Brazelton Neonatal Behavioral Assessment Scale, as presently conceptualized, is not yet appropriate to assess a stressed or premature infant. The interaction of physiological demands in the full-term infant and his capacity to gain control over them in order to interact with social stimuli is not likely to be of the same dimension in the stressed or prematurely born infant. The amount and kind of examiner facilitation which are needed to produce "best performance" in him may be quite different and might indeed be a measure of his instability.

A system-oriented method for presenting and scoring the Brazelton Neonatal Behavioral Assessment Scale must be applied to the assessment of premature infants. We feel that the premature infant's organization could best be captured by separating it into five developmental lines—physiological, motor, state, attention/interaction, and regulatory. The amount and quality of the examiner's efforts become even more critical and/or scored as we observe the baby's capacity for managing his fragile, easily overwhelmed systems in order to respond.



ASSESSMENT OF PRETERM INFANT BEHAVIOR (APIB)
H. Als, Ph.D.
B.M. Lester Ph.D. E. Tronick Ph.D. T.B. Brazelton M.D.
© February 1979

INFANT'S NAME
MED. REC. NO.
DATE OF BIRTH
AGE (Post conception)
TIME – LAST FEEDING
TYPE OF FEEDING
CURRENT INTERVAL BETWEEN FEEDS
INITIAL CIRCUMSTANCES OF INFANT
POSITION ☐ SUPINE ☐ PRONE ☐ SIDE
HEAD ☐ RIGHT ☐ LEFT ☐ MIDLINE
COVERING ☐ DIAPER ☐ SHIRT ☐ CLOTHES ☐ BLANKET(S)
INFANT'S INITIAL STATE
INFANT'S PREDOMINANT STATE
WEIGHT ___ LBS ___ OZS ___ GMS
HEIGHT ___ INCHES ___ CM
HEAD CIRCUMFERENCE ___ INCHES ___ CM
PONDERAL INDEX
DATE OF EXAM
TIME OF EXAM
PLACE OF EXAM
PERSONS PRESENT ☐ MOTHER ☐ FATHER ☐ SIBLING(S) ☐ OTHER ___
INTERFERING VARIABLES
EXAMINER
VIDEO
DURATION OF EXAM

SCORE SHEET I – SYSTEMS
LEGEND B = Baseline R = Reaction P = Post package Status

	ORDER OF PKG	PHYSIOLOGY			MOTOR			STATE			ATTN/INTERACT			REGULATORY			EXAM FACIL
		B	R	P	B	R	P	B	R	P	B	R	P	B	R	P	
PACKAGE I SLEEP/DISTAL																	
PACKAGE II UNCOVER/SUPINE																	
PACKAGE III LOW TACTILE																	
PACKAGE IV MEDIUM TACTILE/VESTIBULAR																	
PACKAGE V HIGH TACTILE/VESTIBULAR																	
PACKAGE VI ATTENTION/INTERACTION																	

COMMENTS:

Figure 3

We have divided the premature infant's responses into developmental lines and the examiner's effort on another line, as shown in Figure 3. As we work with the infant, we are constantly recording the examiner's input—the latency, the pacing, the controls which are necessary from him or her in order to produce the premie's "best performance."

We are coming closer to a "cost-effective" look at organization in the premature infant, to seeing how the different developmental lines interact to create a picture of organization in the fragile premature or sick infant. Through such a picture, the examiner can identify the organizational processes which are already relatively stable, as well as ones which are easily overloaded. With this kind of process-oriented assessment, we feel we can more reliably identify the task for parents who must work with such babies toward optimal organization and function.

Table 3: Qualifiers for the NBAS

1. Quality of Responsivity
2. Examiner Facilitation
3. Cost of Attention
4. Balance of Tone
5. Range and Flexibility of States
6. Regulatory Capacity
7. Robustness and Endurance
8. Control over Input
9. Need for Facilitation and Use of Stimulation
10. Attractiveness

(From Als, et al., [13,17] in press)

Since this scale (the APIB—Assessment of Premature Infant's Behavior) (17) is complex, difficult to learn and hard to score reliably, we have been recommending that a set of ten qualifiers be added to the Neonatal Assessment Scale to make it useful with at-risk and immature neonates. The Scale can then be used as a clinical instrument for assessing these babies after they are out of danger and are in room air in an open crib.

ASSESSMENT AS AN INTERVENTION

It seems to me that there might be several ways for using an assessment of an infant—all of which might be seen as bases for enhancing the infant's development. For example, a single assessment to determine *where* the infant is along the different lines of development might give a professional the necessary "window" into his level of development for work with the baby's family. How the infant performed, the quality of his performance, how much work was necessary to obtain his optimal level of performance could be scored and would be an asset to this understanding. The PDI of the Bailey exam at one year is an example of the same kind of fleshing out of a standard motor and cognitive assessment of an infant.

Another use of an assessment might be to provide a communication system between the professional and the family—for, as the infant performed in the test situation with the parents present, the behavioral responses could be described to the parents, without labelling them, and the parents' reactions ascertained. Parents and professional could then work out mutual goals, using the assessment as a form of communication between them. Having viewed it together, they would share a kind of communication about the baby. This kind of assessment would provide a window into the baby's performance, and by their reactions to it, uncover a window into the parents' feelings. Through the descriptive and visualized sharing of the infant's behavior, parents and professionals could establish rapport, could identify target areas of concern, and could together create a program for his future development.

Table 4: Uses of Assessment in Infancy

1. Development status
2. Communication between professional and parent
3. Understanding process of performance for post- and prediction
4. Use as an intervention

A third use of an assessment might help both professional and parent to visualize and elaborate upon the processes which the assessment suggests have led to the baby's present performance. In such an assessment, one would look for behaviors which point to his past experience, represent a style of coping, and might also predict to his future use of the experiences and the people in his environment.

These three uses of an assessment are different. They achieve different goals, and, as such, they could and should be clearly delineated before a specific technique is chosen.

The first type might be labelled a "single-slice" technique and a stimulus-response kind of assessment. The examiner would use clinical acumen to obtain the baby's "best performance" and to assess his individuality or style in order to make a clinical judgment about him or his parents. The last two would deserve a more clinically oriented technique and an examiner who could not only sense and articulate the nuances and implications of how the baby performs but could also uncover what that style meant to his parents. A single-slice technique and a stimulus-response model of evaluating his performance might miss these clinical implications.

In the last cases, an examiner must be trained with a clear knowledge of the baby's maturation and of parental expectations as well as of the energy and the cost-benefit of maturational lines of development which would affect the past and future of the baby. The examiner would hope to assess the forces from the past which provided the developmental base for the baby's current performance, the *anlage* for a prediction to the baby's future development. In visualizing the baby's style of performance, his way of coping with the test situation, the examiner would see the forces for future coping and assimilation of environmental experiences. Clearly, an interpretation from this kind of assessment is ambitious and dangerous, and, must be carefully controlled.

THE IDEAL ASSESSMENT

An assessment ideal for a clinician's use would have the elements of the past, present and future in it. These pre- and postdictions could become the base for an understanding of the infant. An assessment of an infant should be seen as an opportunity for interaction with an infant, and via the infant's use of the examiner and his materials, one might come to the best understanding of how this infant functions. By entering into the infant's world and reacting with him, the examiner gains an opportunity to understand how the baby's parents will react to him.

If it is to become a base for enhancing the infant's development, the scoring of any assessment of an infant should include an objective recording of the subjective and clinical insights of the examiner. For it will be through these reactions that the examiner can enter into a working relationship with both the infant and his parents to further this development.

We have learned the power of just such an assessment in our work with the Brazelton Neonatal Behavioral Assessment Scale. As we work to reach, to understand, and to envelop the newborn in an adult's containing and facilitating interaction, to obtain his "best performance," we have realized the power of such an "envelope" in providing the baby with an opportunity to show us his processes—of organization, of mastering his immature physiology and nervous system, of achieving an optimal state of attention for interaction with his environment. As he shows us these processes, we can understand them by our identification with him. By such an understanding we can then predict fairly accurately what he will do to those caring adults around him who are also interested in helping him achieve his own best performance.

If we are ready to do so, we can share these observations and these insights with the newborn's caretakers, to join with them in setting goals for his best developmental outcome. An assessment of an infant is a multidimensional opportunity—for diagnosis, for prediction, and for entering the parent-child interaction.

If we really mean to predict from behaviors at one age to another set of behaviors at a later age, we must improve upon the kinds of assessments which we are presently comparing. As a clinician who must attempt to assess the total child and his parents if I am to participate with them in illness, in problems, as well as in health, I must know *how* they will perform under stress as well as in day-to-day living, how their performance is likely to change with the discontinuities of daily life and of development. If I just assess them for cardiac functioning or for cognitive or motor function within any simply developmental line, I will *not* be able to predict from one time to another to what I need to know to help them.

I am making a plea for better or more comprehensive assessment techniques than we now have for children at *any* age. I think statements which imply lack of predictability or lack of continuity are based on rather naive techniques for assessment at present. In other words, we *may* be looking through the wrong windows. Assessments which are more qualitative than quantitative might find coping systems, the *way* the baby uses the examiner and the *way* he is brought to best performance, as significant as his *level* of performance. Such instruments might add another more useful dimension to our predictive capacities.

The most exciting use of our own assessment techniques is that of communication and work with the parents of our study subjects. For we find that studying a group of infants in the presence of their parents automatically changes the study to an intervention study. Although we started out to study the dynamics of recovery and growth in a group of high-risk prematures and in a group of normal full-term infants, we are indeed studying their development within the envelope of caring researchers.

For as soon as recruitment begins, we are already establishing a therapeutic relationship. Our research assistants are more like social workers than psychologists. They recruit and relate to the parents in a very individualized way. We have lost only three subjects over the 2½ years of our study. When we must go to the homes for assessing the premature with the A.P.I.B. and with the Brazelton Neonatal Behavioral Assessment Scale, parents are intimately involved, watching everything we do. They not only ask all of their stored-up questions and openly seek support from Drs. Als and Lester, but they model very carefully on each researcher's behavior in producing the infant's best behavior.

Several studies (14,15) have produced evidence that the demonstration of a newborn's behavior to a mother (and father) significantly affects their relationship to that baby. We are even more convinced of this in the case of a premature infant. Dr. Michael Yogman, who does the pediatric assessments, becomes their pediatrician for medical advice and confirmation, although we have carefully tried to play a secondary role to their own pediatrician.

In our face-to-face paradigm for studying parent-infant play between 3 and 5 months, we have allowed mothers and fathers to observe our videotaped recording of the face-to-face condition. For the normal interactions, parents will watch themselves carefully, identifying successfully for themselves the successes and the failures in the three-minute interactions. After the paradigm in which mothers are instructed to sit in front of the baby with a still face in order to violate the baby's expectancy for her interaction (16) (the babies invariably turn away in utter disappointment), mothers will say, "I never knew I was so important to my baby."

With the premature infants, in the play episode mothers are still likely to be overpowering their babies as late as 40 weeks plus 5 months, and are likely to be playing too active a role, the babies too quiet and passive. In the still-face episode, the 5 month premature comes alive to demonstrate remarkably sophisticated techniques for trying to engage his motionless, unresponding mother. The mothers look with amazement at this videotaped segment and say, "Why, I'm doing too much. He needs to be left to do more for himself!" Each observation becomes a therapeutic intervention and an opportunity for the parents to observe the baby and themselves in a more objective setting. Parents tend to work to right the imbalances toward more optimal development. Each Bayley assessment, each pediatric and behavioral assessment becomes just such an opportunity for capturing parents and letting them see themselves more clearly in their parental roles.

Ours has become a study of the opportunities for enhancing infant development within the study and assessment of development of at-risk and normal infants. The way parents use us and our techniques, then, becomes our most critical measure of the energy for recovery his parents can offer the infant. It is no wonder, then, that our premature and full-term infants are thriving within the paradigm of a longitudinal study.

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Reminder:

- Register for Training Institute December 4-6
- Renew subscription to Zero to Three (use coupon on page 15)

For Your Information:

1982-83 Congressional Science Fellowships in Child Development: Administered by the Society for Research in Child Development and the American Association for the Advancement of Science, these fellowships allow six postdoctoral scientists or professionals interested in public policy to spend one year as a member of a Congressional staff. Mid-career applications from the social, behavioral and health-related sciences are especially encouraged. The fellowship year begins September 1, 1982; the deadline for receipt of application materials is November 16, 1981. Contact Dr. Barbara Everett, Washington Liaison Officer, Society for Research in Child Development, 2025 Eye St., N.W., #905, Washington, D.C. 20006, tel: (202) 887-0977.

Methods and Results Requested for Meta-analysis of Infant Intervention: A meta-analysis of infant intervention programs is being conducted under the auspices of NIMH's Office of Prevention and Mental Health Study Center. Meta-analytic techniques are designed to group data across a large number of studies in order to determine the relative impact of various intervention procedures. The meta-analysis will include outcome measures in the areas of socio-emotional, physical (medical) and cognitive development, and school achievement and will be used to create guidelines and recommendations for effective early intervention. Researchers and interventionists are requested to send program descriptions and results (as much raw data as possible, please) of early intervention to: Bernard J. Shuman, M.D. and Frank Masterpasqua, Ph.D., Center for the Urban Child, 112 N. Broad St., Philadelphia, PA 19102, tel: (215) 568-0860.

Calls for Papers:

World Association for Infant Psychiatry: "Infancy in a Changing World" will be the theme of the Second World Congress on Infant Psychiatry scheduled for March 29-April 1, 1983 in Cannes, France. Send abstracts of no more than 500 words to Justin D. Call, M.D., Chief of Child and Adolescent Psychiatry, UCI Medical Center, 101 City Drive South, Orange, CA 92668.

National Association for Perinatal Social Work: Proposals are now being considered for presentations at the Association's May, 1982 conference on "New Directions in Perinatal Social Work" which will take place in Houston, Texas. For further information contact conference Chairpersons Helen Grace or J Miller, Social Service Department, Jefferson Davis Hospital, 1801 Allen Parkway, Houston, TX 77019, tel: (713) 751-8352 or (713) 751-8434.

UNITED SERVICES FOR EFFECTIVE PARENTING: A GRASS ROOTS APPROACH TO CHILD AND FAMILY ADVOCACY

by Earladeen Badger
President, USEP-OHIO

If something, no matter how worthwhile, goes on in a vacuum, it will never make any difference except to those people directly involved. I became convinced of the truth of this hypothesis during the years I spent, first, in a university setting developing a program to train mothers of disadvantaged children in infant stimulation (1) and, later, advising federally funded Parent-Child Centers attempting to build infant enrichment programs in urban and rural areas across the country. For a number of reasons, model programs bred at universities often failed to thrive when transplanted to communities by organizations like the Parent-Child Centers. However, I had experienced success both in the university and in rural parent-child programs in Southern Illinois and Northwest Georgia. And when I began in 1973 to develop the Infant Stimulation/Mother Training (IS/MT) program within the Newborn Division of the Department of Pediatrics, University of Cincinnati College of Medicine, my colleagues and I had replication in mind from the outset.

The cadre of professional volunteers—nurses, social workers, and teachers interested in continuing education—we attracted to the high-risk group of parents (mothers 16 years and younger delivered at Cincinnati General Hospital) we served were committed to begin at the beginning, and to provide comprehensive health, educational, and social services in a humanistic manner in our weekly mother-infant classes.

The interest in the IS/MT program within and outside the medical center assured me that this early educational intervention model was not going to occur in a vacuum. Based on the success of the pilot program, which was both research- and service-oriented, we began an adapted service program, recruiting a new group of mother-infant pairs each month (ninety groups of 10-12 mother-infant pairs, or almost 1000 mothers, have completed the program to date) and training a new instructor with each series of 20 weekly classes.

These newly-trained program deliverers soon formed a network of people and agencies. But since sponsoring agencies for the most part provided only incidental funding, we realized that outside support and consultation for these programs would be needed. Coordination, accountability, and coalition building would also be necessary if parent-infant programs were to be more than a fad of the Seventies.

USEP BEGINS

Beginning in 1974, a small group of diverse program deliverers, meeting informally on a monthly basis at the College of Medicine, formed United Services for Effective Parenting (USEP). Representing a variety of agencies and professional disciplines, they all served the 0-3 population and their families. They hoped to pool their information about how best to serve at-risk infants and their parents. And, in the absence of any substantial funding for early educational intervention and in a state which has no mandate to serve children at risk for developmental delays under three years of age, program survival was an immediate concern.

From 1974-77, participating USEP agencies increased from six to sixteen in Cincinnati. USEP became a nonprofit corporation with offices within IS/MT Program at U.C. College of Medicine. Its four goals—1) to develop a support system for program deliverers; 2) to offer consultation to the membership and community at large; 3) to coordinate parenting/birth-to-three programs; and 4) to establish a central referral system—have been carefully documented so that a community coordinated delivery system of birth-to-three programs as translated in the USEP model could be replicated elsewhere.

In the early stages of USEP's development, mutual support and professional growth grew through the sharing of information and resources. This occurred formally through monthly luncheon meetings and informally when educational materials (books, films, and toys) or consultation were shared. A spirit of camaraderie prevailed. Cooperation replaced competition as the small group serving the birth-to-three population recognized that an unlimited supply of families who needed and wanted services existed.

The attractiveness of the mission appealed to a diverse group of professionals: teaching nuns who had left the Catholic school system to work with young children and their parents in inner-city homes; public health, hospital, and clinic nurses who wanted to redefine their role as educators and nurturers of parent-infant pairs; professional mothers who were reentering the job force through volunteer work in YWCA, Birthline, and Parent Cooperative programs; and social workers from traditional agencies—Family Service, Catholic Social Service, Jewish Family Service—who began to evince interest in early intervention.

Potential program adopters could choose from several training options: one-day workshops; seminars; on-site visits; practicum experience in the IS/MT Program; and four-day short courses. Through the offering of four-day short courses, we began to attract practitioners from other parts of Ohio and out of state. (To date, 524 persons from 32 states have attended one of our 20 short courses). As had been true in Cincinnati, they came from a variety of public and private agencies and professional disciplines. Most came to learn how to set up a program and expressed concern about the kinds of help and support they would need in order to be successful when they returned to their communities. This concern provided the impetus for replicating USEP in other parts of Ohio. And our expanding network of program developers throughout the state gave us a nucleus of leadership on which to build.

DEVELOPING A BROAD-BASED CONSTITUENCY

We decided to launch USEP as a statewide coalition for birth-to-three program providers at a one-day "decision makers" symposium held on May 17, 1977 in Columbus, Ohio. We invited a mix of forty state government department heads, educational developers, and researchers. Outside experts Drs. J. McVicker Hunt from the University of Illinois and Howard Garber from the Milwaukee Project were on hand to present their data in support of early educational intervention. Although interested and supportive, state leaders and researchers were not among the 12 people who agreed at the end of the day to serve on a steering committee to develop a state agenda and constituency for birth-to-three programs. Remarkably, it was the educational developers who saw themselves as change agents. These were professionals like myself—early childhood educators, special educators, child development specialists, and developmental psychologists—who were designers/implementors of university, medical center or public school early intervention models which used federal funding for the poor or the handicapped. They were leaders in their respective service delivery systems.

The immediate agenda of the 12-member steering committee was: 1) to locate the birth-to-three programs in Ohio; 2) to develop and circulate a program questionnaire which would assess the quality of these programs; and 3) to plan a conference so that all program providers could meet and share information with one another. The first two agenda items were easily accomplished through the cooperation of County Extension Agents whose work is directed by the Departments of Home Economics in state-supported land grant universities. Their physical presence in each of the 88 counties expedited the distribution, completion and return of completed questionnaires to the Cincinnati USEP office. We found 167 programs serving the birth-to-three population in Ohio. An overwhelmingly positive response to the question, "Would you attend a two-day conference for birth-to-three practitioners?" signalled the go-ahead for a conference in May, 1978.

PHOTO BY BARBARA YOUNG

Members of the USEP steering committee viewed all 111 participants at the first statewide conferences more as a panel of experts than as a relatively passive audience. We wanted not only to develop a state-of-the-art paper on birth-to-three programs in the state of Ohio but also to enhance the personal and professional development of the program deliverers by maximizing their role as participants. Workshops gathered data on program logistics, intervention strategies, putting child development theory into practice, and program evaluation. Journalistic reports were prepared on the content of all four workshops. And, at the end of the conference, the participant-observer role played by the program deliverers seemed to influence their unanimous decision to replicate the USEP model in their own geographic areas and to adopt USEP's name.

This effort included beginning regional chapters which would 1) develop central referral systems; 2) share program resources through monthly meetings; 3) provide program consultation to USEP members and the community at large; and 4) serve as advocates for the birth-to-three population and their families. Further, the participants charged the steering committee, as their elected representatives, 1) to plan annual statewide USEP conferences, 2) to publish a directory of the 167 birth-to-three programs, and 3) to publish a bi-monthly newsletter. As a project funded by the Handicapped Children's Early Education Program (HCEEP—Office of Special Education, U.S. Department of Education), the IS/MT Program coordinated and completed these tasks as part of its demonstration, training, and dissemination activities. Without federal or state funding of this kind, the resources to complete the activities of USEP-OHIO would not have existed.

In order to accomplish all that was promised, the twelve member steering committee was enlarged to thirty. New members were selected to provide geographic representation from all parts of Ohio. They agreed to meet as a body on a bi-monthly basis and to serve as regional organizers in implementing the goals of USEP.

USEP-OHIO became a non-profit corporation in September, 1978, with its principal officers based in Cincinnati and the steering committee appointed as its Board of Trustees. (At the regional level, the Board Members are identified as the Ohio Council.) Operating expenses—postage, publications, telephone—are absorbed by the Department of Pediatrics at U.C. College of Medicine. Annual membership fees of $10 support the annual conference. IS/MT staff—director, coordinator of USEP central referral system, secretary—coordinate all of USEP-OHIO's activities as part of their job descriptions.

A STATEWIDE COALITION

Almost three years have passed since USEP became a statewide coalition. Twelve regional replications of the Cincinnati model are currently operating. USEP's corporate officers and Board of Trustees—who are also the regional organizers—meet bi-monthly to plan the annual conference, the newsletter, and advocacy efforts on legislative and programmatic issues. At the regional level, monthly meetings scheduled by members of the Ohio Council and program deliverers are guided by the same goals defined by the Cincinnati chapter. While progress as measured by involvement varies among regions, all chapters continue to expand their membership.

We have observed a phenomenon of growth in both the original USEP model in Cincinnati and the statewide organization which may intrigue other organizers and network builders. During the first year, an enthusiastic approach to a new job carries a group quite a distance. During the second year, a settling-in period occurs, which requires formative evaluation in order to change or modify whatever conditions seem to stultify growth. This period can cause some leaders to feel stymied or unsuccessful. With reorganization and continued momentum, however, the third year is a breakthrough in the change process which results in an institutional product.

In spite of limited and piecemeal funding, birth-to-three programs in Ohio continue to grow in number. A new State Directory will include more than 300 programs, and in Cincinnati alone sixteen programs existing in 1977 increased to thirty-three programs by 1981.

USEP's constituency has broadened, with a large influx of both hospital-based programs and middle-class parents of firstborns who are eager for information in order to develop self-help programs. Capitalizing on the interest of these new constituents, USEP intends to move aggressively in the coming year to recruit perinatal health care providers and pre- and post-natal childbirth and parent education groups as affiliate members. We also expect to amplify our voice for children on legislative and programmatic issues through our recent alliances with Ohio Association for Young Children and the Perinatal Network.

DEVELOPING LEVERAGE POINTS IN GOVERNMENT

At the state level, USEP has attracted the interest and support of the Departments of Health, Special Education, Vocational Education, Mental Retardation/ Developmental Disabilities and Mental Health. In a state known for its conservatism, however, the fact remains that there is only token funding of primary prevention programs. Nonetheless, we do have the ear of the program planners and our position has been clear: we will deliver the constituency and the agenda for very young children and their families. This position offers support to state department heads going before legislative committees to defend their programs. And, as block grants to states become a reality, USEP intends to intensify its advocacy efforts in behalf of children.

Since the structure of USEP-OHIO permits members of the Ohio Council to speak for USEP members in their geographic regions, we have been able to collectively represent the membership of USEP on statewide child- and family-related issues such as the caregiver-child ratio in infant day care centers, corporal punishment in the public school system, and non-categorical treatment for preschool children in special education programs. In addition, we have been able to write letters of support for the proposed and continued funding of birth-to-three programs and to testify in behalf of these programs at the Ohio Commission for Children and Title XX public hearings. At this point, our regular letters to state and federally elected representatives have only served to let them know that very young children and their families *are* a constituency in Ohio. With continued practice and the personal and professional development of the leadership of USEP, we expect to make this a constituency to be reckoned with.

At the federal level, USEP has been enormously appealing to bureaucrats who have learned that to "mandate" coordination of programs at the local and state administrative levels as a condition of funding does not make such coordination occur. This should come as no surprise, as evidence suggests a substantial lack of coordination of child and family oriented programs at the federal level (4,5).

Division directors in the Department of Education and in mental health, developmental disabilities, and maternal and child health programs were quick to realize why USEP "works" as a model for coordinating and strengthening program delivery. First, it is a grass roots organization, and membership and involvement are voluntary. Second, it is easier to get people to cooperate at the program delivery level, where competition and turf-guarding are not as common as at the administrative level. And third, program deliverers are in touch with the people they serve and are able to function as humanists. Each of these reasons argues for increased involvement in the formation of public policy at the grass roots level, and collectively they speak to the kind of personal control and satisfaction we all hope to achieve in our work.

PHOTO BY ROBERT MAUST

CONCLUSION

Stimulating national political action in behalf of children may be begging the real question—how to build a more just society. Historically, children have fared badly in our societal efforts to narrow the gap between our political ideals and our economic realities (6). If, despite rhetorical claims that "children are our most important product," the needs of children are *not* a national priority and we cannot influence and persuade at the national level, then we must concentrate our efforts on building from the bottom up.

What I have described is how one coalition is working at the local and state levels to improve the quality of life for very young children and their families. USEP's appeal is that it arose from voluntary action at the grass roots level. Its uniqueness is that it promotes effective parenting for *all* parents; it is concerned with the primary prevention of handicaps in *all* population groups. Its strength is the quality of people it has attracted as leaders and program providers.

A conference for those interested in replicating the USEP model in states outside Ohio will take place at the Mercy Conference Center in Cincinnati April 27-29, 1982. For information contact Earladeen Badger or Donna Burns, Dept. of Pediatrics, U.C. College of Medicine, 231 Bethesda Ave., Cincinnati, OH 45267, tel: (513) 872-5341.

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National Center Notes:

by Eleanor S. Szanton

As of this writing, the prolonged effort to make major cuts in the federal budget continues, beginning with the appropriations process in September. Actual appropriations may be significantly lower than what was authorized. Nonetheless, the *structure* of federal expenditures for health, education and many social services has remained largely intact. The effort to throw many programs into a single block grant has been substantially defeated. Specifically:

- The Medicaid program has not been capped. However, its Early and Periodic Screening, Detection and Treatment (EPSDT) regulations, though now clearly written to apply to all Medicaid-eligible children, have abolished penalties for non-performance.

- Maternal and Child Health Programs have been put into a mini-block grant, including the old Title V, Sudden Infant Death Syndrome (SIDS), genetic diseases, supplemental services for disabled children, lead-based paint poisoning, and adolescent pregnancy. Its administration and some of its research and demonstration funds are partly maintained at the federal level.

- Mental health services have been folded into a mini-block grant with alcohol and drug abuse programs. Funds for community mental health centers will soon be shifted to the states. Special provision for children, previously identified as an "underserved population," has been removed. Federal funds for mental health training and services will be abolished.

- A "prevention" block grant includes home health, urban rat control, and fluoridation programs.

- Title XX has become a mini-block grant. Matching funds in daycare are no longer required from the states, and there are no remaining special incentives for using these funds for daycare.

- Foster Care and Adoption Assistance remains as a separate authorization, as do Education for the Handicapped, Child Abuse Control, Developmental Disabilities, and family planning, migrant health center and immunization programs.

- Maternal and child nutrition programs exist more or less intact at this time, including the Women, Infants and Children (WIC) and child care food programs.

Again we urge you to join with others in your states and regions to make known the needs of infants and their families. We hope to carry reports of such efforts, like the Ohio program described by Earladeen Badger (on p. 9 of this issue).

Respondents to the questionnaire about **Zero to Three** in our last issue included individuals in psychology, child development, psychoanalysis, pediatrics, social work, special education, nursing, and administration. They live in all regions of the country and work in hospitals and clinics, private and public local service agencies, schools, state and regional agencies or planning organizations, private practice, universities, and local advocacy groups. Most respondents were pleased with the publication. They found the theoretical pieces and program profiles most appealing, though the conference notices and publications section were also rated high. (Now is the time to renew your subscription for Volume II of **Zero to Three**. Please use the coupon on page 15.)

Perhaps most interesting of all were the suggestions for types of articles not presently offered. We will keep these in mind for planning future issues. They fell into four categories: 1) *further services for readers*: listings of opportunities for training or jobs, opportunities for funding, earlier and regional listings of conferences, including calls for papers; 2) *more directly job-relevant material*: a state planner wanted a more thorough legislative review; a pediatrician wanted more specifics on techniques of assessment; 3) *more cumulative reviews of the research literature, including longitudinal studies*: such as the effects of infant day care, teen parenthood, early prevention and intervention programs, cost-effectiveness data; and 4) *information to help practitioners join forces to advance the state of the art*: to know of joint research projects, to work toward "the consolidation of fragmented research reports."

These last two categories are directly relevant to some thinking being done by the leaders of the National Center. One of our goals always has been to broaden and deepen the level of discourse among policy makers on issues touching the lives of our nation's youngest people. In this context—and in the present climate for funding of child welfare programs—we have determined to assemble evidence to demonstrate for public policy makers and third-party funders the cost-effectiveness of early intervention. We plan to integrate data from diverse sources in order to make a convincing finding. We will keep you informed as this effort moves along and would welcome readers' suggestions on identifying and assembling data.

Registration for our December Training Institute is climbing, with a strong response to the preliminary brochure mailed early in July. Our fifty-member faculty includes leaders in the field from a broad range of disciplines. We look forward to a vigorous interchange between faculty members and participants. Since the final Institute brochure is now on its way, I suggest that you sign up as soon as possible to be assured of space.

Publications:

Infants at Risk: Assessment and Intervention—Catherine Caldwell Brown, editor, introduction by T. Berry Brazelton, M.D. (Johnson & Johnson Baby Products Company, 1981) $5.00.

Fifteen authors from a range of disciplines contributed to this fifth publication in Johnson & Johnson's Pediatric Roundtable Series. Summarizing discussions on "New Approaches to Developmental Screening of Infants," the book reviews new assessment techniques and strategies for their application to early remedial intervention. The authors also examine communication between the professional in clinical practice and the parents of the child at risk.

PHOTO BY ROBERT MAUST

Infants: Their Social Environments—Judith S. Musick and Bernice Weissbourd, editors (Washington, D.C.: National Association for the Education of Young Children, 1981) $7.00.

The editors of this book assume that human beings' efficacy, competence, and knowledge of the world are powerfully influenced by the quality of the early social and caregiving environments. They note that while psychological needs of infants remain the same, rapidly changing social conditions are producing changes in children and families that may profoundly influence development.

Infants: Their Social Environments reflects the ever-closer connection between research and the application of research findings, especially in the area of social policy. The twelve essays are fairly evenly divided among those which discuss recent infancy research, those which review intervention programs, and those (like Laura Dittman's "Where have all the mothers gone, and what difference does it make?") which examine social phenomena and policy issues.

The Earliest Years—July-August, 1981 issue of *Children Today* (DHHS Pub # [OHDS] 81-30014, Superintendent of Documents, U.S. Govt. Printing Office, Washington, D.C. 20402) $2.00.

NCCIP Chairman Reginald S. Lourie and Secretary-Treasurer Robert A. Nover worked closely with *Children Today*'s editors in producing this special issue, which draws upon new knowledge of infant and prenatal development and the interacting influences of parents on child and child on parent.

Articles by National Center Board members include:

- T. Berry Brazelton and Steven Parker—"Newborn Behavioral Assessment"
- Reginal S. Lourie—"Primary Prevention in Infancy"
- Stanley I. Greenspan—"Adaptive and Psychopathologic Patterns in Infancy and Early Childhood"
- Robert A. Nover, Delise W. Williams and Delois B. Ward—"Preventive Intervention with Infants in Multi-Risk Factor Families"
- Sally Provence and Albert J. Solnit—"Obstacles to Early Assessment and Treatment of Infants"

Other articles discuss the effects of alcohol, smoking, and other toxins on fetal development; malnutrition and mental development; and new programs for the hospital care of infants at risk.

Newborns and Parents: Parent-Infant Contact and Newborn Sensory Stimulation—V. L. Smeriglio, editor (Hillsdale, NJ: Lawrence Erlbaum, Associates, Inc., 1981) $19.95.

The nature of hospital environments experienced by newborns and their parents varies considerably, and researchers, clinicians, and parents are understandably interested in the effects of such experiences. This book analyzes the current state of knowledge regarding outcomes and suggests further directions for study. One group of essays deals with newborn sensory stimulation by equipment or hospital personnel, the second with parent-infant contact. Among the sixteen contributors are Kathryn Barnard, T. Berry Brazelton, John Kennell, and Anneliese Korner.

The Nurse and the Childbearing Family—Deborah Blumenthal Bash and Winifred Atlas Gold, editors (New York, NY: John Wiley & Sons, Inc., 1981) $21.00.

This maternity nursing text examines pregnancy, childbirth, the antepartum period, and family planning. It discusses the characteristics, needs, and possible problems of the fetus/newborn, *both* of its parents, and other family members. Nursing interaction with "the childbearing family" is emphasized throughout the volume. The text describes new techniques of fetal and infant assessment; appendices include case studies, a maternal-infant interaction assessment guide, and maternal and neonatal record forms.

Conference Call:

October, 1981

October 8-10: *The National Black Child Development Institute* will hold its Eleventh Annual Conference in Washington, D.C. Seminars in Child Development, Child Welfare, Education, and Research will discuss such topics as financing for child care and Head Start and black child-rearing patterns. Write or call Vicki D. Pinkston, NBCDI, 1463 Rhode Island Avenue, N.W., Washington, D.C. 20005, tel: (202) 387-1281.

October 14: *Christ Hospital* of Oak Lawn, Illinois will feature a presentation by Tiffany Field on "Long Term Follow-up of the High Risk Newborn, Outcomes of Early Intervention" at its first annual symposium in developmental pediatrics. For further information, call the Developmental Pediatric Symposium Chairperson at (312) 425-8000, extension 5675.

October 17: *The Missouri Perinatal Association* will sponsor a special seminar on infant development in Columbia, Missouri, with guest speakers John H. Kennell and Stalnley I. Greenspan. To register, contact Weldon Webb, Office of Continuing Education and Extension, M240 Health Sciences Center, Columbia, MO 65212, tel: (314) 882-2256.

October 14-18: *The American Academy of Child Psychiatry* will meet in Dallas, Texas. The program will include an update in neonatology for child psychiatrists and sessions on neonatal hospice care, the influence of early malnutrition, and "Issues in Infancy." Contact the AACP, 1424 16th Street, N.W., Suite 201A, Washington, D.C. 20036, tel: (202) 462-3754.

November, 1981

November 1-5: The 109th Annual Meeting of the *American Public Health Association* in Los Angeles, California will include presentations on prenatal education, home visitor parent support programs, delivery of prenatal care, the childbearing adolescent, and promoting maternal and child health in a time of retrenchment. Write to Continuing Education Program, APHA, 1015 Fifteenth St., N.W., Washington, D.C., 20005, tel: (202) 789-5600.

November 6-7: *The Center for the Study of Infants and Their Families* (a division of the Family Health Research, Education and Service Institute) will sponsor an Interdisciplinary Seminar on Family Adaptations to Childhood Disability at Alma College, Alma, Michigan, with the aim of increasing professionals' ability to offer useful assistance to families. Write to Family Health Institute, 503 N. State Street, Alma, MI 48801.

TIME TO RENEW!

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CONFERENCE CALL

continued from previous page

November 5-8: "Building on Behalf of Children" will be the theme of the Annual Conference of the *National Association for the Education of Young Children* to be held in Detroit, Michigan. Some sixteen presentations will focus on infants and toddlers; a preconference session will look at family day care issues. Contact NAEYC Registration, 1834 Connecticut Avenue, N.W., Washington, D.C., 20009, tel: (202) 232-8777 or (800) 424-2460.

November 8-10: The National Perinatal Association and the Vanderbilt University School of Medicine will co-sponsor a seminar on "Realities of Today's Perinatal Health Care Delivery" in Dallas, Texas. Write to the NPA, 1311-A, Dolley Madison Boulevard, McLean, Virginia 22101.

November 16-21: *The National Easter Seal Society Convention* in Tulsa, Oklahoma will devote its November 17 professional program to "Early Detection and Intervention." T. Berry Brazelton, Barbara Bowman, Bettye Caldwell, and K. Allison Clark Stewart will speak. Write to the National Easter Seal Society, 2023 W. Ogden Avenue, Chicago, Illinois 60612.

November 20-23: The Thirty-third Annual Meeting of the *American Association of Psychiatric Services for Children* will explore "Financing and Public Policy in the Delivery of Services to Children" in San Francisco, California. Write or call William E. Stone, M.D., AAPSC, 1725 K Street, N.W., Suite 1112, Washington, D.C., 20006, tel: (202) 659-9115.

Zero to Three

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Bulletin of the
NATIONAL CENTER FOR CLINICAL INFANT PROGRAMS VOL. II, NO. 2 DECEMBER 1981

TWELVE TO EIGHTEEN MONTHS: THE STAGE OF THE SECOND YEAR

from *Psychopathology and Adaptation in Infancy and Early Childhood: Principles of Clinical Diagnosis and Preventive Intervention*

by Stanley I. Greenspan, M.D.

Stanley Greenspan's new book launches CLINICAL INFANT REPORTS, a new venture of the National Center for Clinical Infant Programs. This series of publications will feature reports of empirical and developmental research; clinical case studies; practical program descriptions; clinical studies relating to diagnosis, prevention, and treatment; and reports of conferences relevant to issues in clinical practice.

The excerpt below may give readers the feeling of reading the second installment of a fascinating story, and indeed in a way that is true since it concerns older infants, ages 9-24 months. Greenspan's developmental structuralist framework focuses on how an individual at each stage of development organizes experience. Among the strengths of this theoretical approach are its consistency with research on early development and its clinical relevance.

In the book, six stages of emotional and cognitive experience are defined in terms of the organizations or structures that are dominant. Detailed examples of adaptive and maladaptive behavior and of adaptive and maladaptive environments as well as principles of preventive intervention and treatment are spelled out for each stage. Specific approaches are made vivid through the use of case material drawn from the research project of Greenspan and his colleagues.

Sally Provence, M.D.

As a child moves into the second year of life, he has the capacity for more organized behavioral and emotional patterns, for forming original behavioral schemes, and for increased imitative activity and intentionality. For example, he can make his needs known in an assertive, organized way, taking his mother's hand, pulling her to the refrigerator when he is hungry, motioning her to open the door and pointing to his favorite food. When a hungry 16-month-old behaves in such a fashion, he has told one much about his appropriate cognitive, social and emotional development, as opposed to the behavior of a toddler of the same age who still cries as his only way to communicate.

PHOTO BY ROBERT MAUST

A type of learning through imitation shown in earlier development now seems to take a more dominant role. As imitations take on a more integrated personal form, the toddler appears to adopt or internalize attributes of his caretakers. Together, these new capacities can be thought of as constituting the stage of Behavioral Organization, Initiative and Internalization.

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INFANT CAPACITIES

The optimal toddler can enter into complex interpersonal communications. He and his parent can share a game involving exploration, anticipation, and joy. For example, the child may gesture to the parent to "chase me around the room." When the parent does so, the toddler ducks into a closet and later doubles back to sneak up on the parent, laugh joyously, and jump into the parent's arms with a hug and kiss. Similarly, the toddler can be mischievous in a complex, organized manner when he is angry. He may leave his toys scattered around, arrange for himself or his parents to trip over things, and pretend to be upset. While in earlier stages we might see one or two behaviors tied together in causal links (e.g., a child smiling, the parent smiling, the child returning a smile, or the child vocalizing reciprocally with the parent), now we can see, as in the chasing game, the causal stringing together of several related patterns of behaviors.

The toddler also begins to integrate polarities of feelings, such as pleasure and anger. The optimal toddler is neither confined within solely obsequious, unassertive, seemingly passive states, nor polarized into chronic anger and irritable behavior. Rather, he can organize both these polarities into a range of complex behaviors and can respond to organization and limits in the environment.

More complex sensory-motor patterns and the capacity to abstract functional patterns from inanimate stimuli (e.g., using a toy telephone or play spoon in an appropriate manner) further indicate the greater organization at all levels of development.

PHASE-SPECIFIC DISORDERS

Disorders at this stage may compromise the beginning of internal "psychological" life. Behavior remains fragmented, related to somatic or external cues. Intentionality and sense of self are blocked.

Specific disorders of this phase include a wide range of problems. These can vary from a complete lack of imitation, intentionality, and organized emotional and behavior systems in the child to circumscribed limitations in emotional or behavioral systems, such as assertion or affiliation. Symptoms may include chronic temper tantrums, inability to initiate self-control, lack of motor or emotional coordination, extreme chronic negativism, delayed language development, and relationships characterized by chronic aggressive behavior.

A severe disorder at this phase affects the basic capacity for organizing behavior and forming the precursors for organized mental representations. One can see the results of such a structural defect in adult patients whose behavioral organization and internal representations become disorganized or who cannot form or tolerate affects and even rudimentary percussions of internal imagery related to the interpersonal world, as in certain borderline and psychotic states, severe substance abuse, and psychosomatic and impulse disorders.

A less severe disorder at this stage will be reflected in the narrowness of the range of experience organized, as seen in extreme character rigidities. Such individuals are tied to concrete, immediate states of need fulfillment and are often locked into rigid, narrow behavior patterns reflecting extreme affective and behavioral polarities (e.g., passive, compliant, or aggressive, negativistic.) They either lack utterly a capacity for such broad ranges of affect and behavior as pleasure or assertiveness or possess unstable potentials, which are vulnerable to the slightest stress.

Symptoms at this stage are related to an inability to form organized behavioral and emotional patterns and can be clearly differentiated from symptoms emanating from earlier stages of development. For example, without support from the environment a youngster

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capable of contingent responses, ready for more organized independent behavior, will experience the phase-specific disorders. Such a youngster may also become immensely frustrated with an over-controlling, intrusive, or overly symbiotic caretaker. Sleep disturbances, negativism, chronic aggression, or hyper-irritability and/or withdrawal may emerge as reactions to this frustration. Basic attachments and comforting functions may become temporarily disrupted, and one may see attachment and homeostatic disorders.

PHOTO BY BARBARA HADLEY

In contrast, a youngster who never established homeostatic security, attachment, and a broad range of contingent responses will evidence a history of earlier structural compromises and will more likely have chronic symptoms involving gross developmental delays. The stage-specific symptoms will *not* be on a foundation of regulation, attachment, and appropriate reading of simple signals. The compromises will be *chronic* rather than temporary regressions in earlier functions attributable to frustration at this new level.

THE ADAPTIVE ENVIRONMENT

During this stage of development, the adaptive environment is comfortable and unconflicted about admiring the toddler's new abilities and greater initiative and originality. It is available, tolerant and firm when necessary. It follows the youngster's lead, supporting his initiative and helping him organize one step further than he is able to do on his own.

The optimal caretaker not only admiringly enters into a game with the toddler, but permits him to shift the game, and will help him reorganize if it becomes necessary. For example, child and caretaker may begin looking at pictures together. The toddler then shifts to a chasing game. As the youngster becomes somewhat disorganized, the adaptive caregiver may bring the youngster back to the point from which they started—looking at pictures in a book, helping the youngster name objects. The adaptive caregiver helps the youngster complete the circle.

The adaptive environment is not threatened by affective expression ranging from extreme pleasure to protest and assertiveness, but rather helps the youngster integrate these polarities into meaningful, organized interpersonal responses. When the adaptive environment observes that the youngster is maintaining an organized negativistic or chronically aggressive pattern, it will try to identify those events or experiences which may be heightening the child's sense of frustration.

Parents may notice, for example, that the stress caused by their own work concerns has made them emotionally unavailable to their child and will respond to the child's negativism and chronic aggression not by scolding and punishment but rather by attempting to shift the youngster's attention to more intimate, pleasurable activities. The youngster's realization that he *can* shift and reenter the more emotionally satisfying relationship to his parents helps him tie together his angry feelings with satisfying experiences. Once a pleasurable, supportive milieu is established, firm limits with alternative potentially satisfying experiences further help the child gain a sense of internal control and a bridge between affective polarities.

THE DISORDERED ENVIRONMENT

In the disordered environment, the primary caretakers may be conflicted about the toddler's new independence and originality. They may be able to engage the infant only in fragmented units of interpersonal involvement. For example, the mother is capable only of relatively brief causal exchanges, such as a smile in response to the toddler's smile. When the toddler tries to develop the reciprocal smiling into a pleasurable game, by showing her some toys to arouse her interest in him, the mother's own depression, preoccupation with other issues, or basic personality limitations cause her to become distracted and withdrawn. The toddler's desire to develop and consolidate these more organized patterns never gains support from the animate environment.

Some caretakers, in contrast, may intrude and control the child. Instead of developing initiative and autonomy in the context of organized patterns, the toddler finds that he is being undermined even when his play is curious, original, and potentially satisfying. Some youngsters give up, becoming apathetic and passive. Others try to retain their initiative, but organize their behavior (often in highly original ways)

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around negativism and aggression. Still others surrender investment in the human, animate world and instead develop complicated relationships to the inanimate world.

COMMON FEARS IN THE CARETAKER

A toddler's new capacities may arouse pride and admiration in his parents, feelings which may help them remain available when their child needs support and reassurance. On the other hand, a toddler's greater behavioral organization, initiative and originality, and independence may awaken feelings which may interfere with parents' ability to support the child's development effectively.

PHOTO BY BARBARA YOUNG

Many parents fear being rejected and/or abandoned. A mother who has provided love, support and security for her baby, for example, may say that she and her baby are "like one." Being "like one" may have been extremely useful during the first year of life. But when her toddler no longer wants to sit on mother's lap all the time and begins to move around the house, exploring by himself, the mother may feel abandoned or rejected. She may then pull away and not be available, or she may try to overcontrol the child, not permitting him to explore freely.

While the toddler does not need his mother in the same way he did as an infant, he still needs the warm, loving exchanges they had shared, though he needs them intermittently. The importance of parents' emotional commitment to the child and their ability to take pride in his achievements while remaining available for support cannot be overemphasized. If parents can experience and acknowledge some sense of loss over their child's new abilities, along with their pride and admiration, they will often be able to empathize with their child, who feels a tinge of loss for what is left behind even as he delights in his new abilities.

A fear which seldom manifests itself as openly as the fear of rejection is concern about the toddler's "taking control and being the boss." Here the parents perceive the child's new sense of initiative as "a strong will" and his ability to be more organized and independent as wanting "to run the show." If this parental feeling becomes too strong and outweighs the admiration and pride in the toddler's new abilities, it can set the stage for a power struggle that may last years or even decades.

Parents may read frightening portents into a youngster's emerging capacities. If they misread their child's originality as aggressiveness, for example, parents may have difficulty. One rather passive father, concerned that he was going to have a "hyperactive, aggressive, out-of-control" child, would say, "You've got to tame him early." Seeing his toddler's organized initiatives as aggression, the father quickly intercepted and blocked each avenue for assertive behavior. Not surprisingly, this very competent, industrious youngster became negativistic, belligerent, and disorganized in his aggression. He alternated between disorganized aggressive play and clinging behavior.

The father felt his prediction had come true. However, in discussion, he revealed in greater depth his fears that his son would turn out like a very aggressive younger brother, who had been labeled "hyperactive" and had had learning problems in school. When the father saw that he was misperceiving his youngster's industry, he was slowly able to shift his perception and feelings, so that his wonderfully confident toddler could begin to use his assertive capacities with some support and admiration from his parents.

Setting limits is difficult for many parents. Some feel they have to "tame" their children and may undermine initiative and curiosity, capacity for organization, and eventually the children's ability to set limits for themselves. Other parents are afraid to set limits. In both extremes, the parents' difficulties with fears of "going out of control" and aggression are often prominent.

Toddlers who do not immediately display the kind of industry, curiosity, and initiative expected for their age and who cling to their parents instead are another cause for parental concern. Although these children can walk and say a few words, they do not use these abilities, almost as if they were fearful of taking the next step in development. Instead of offering comforting encouragement, their parents may become alarmed by their children's neediness or dependency, fearing that he or she "will never grow up, will never leave us alone and will always be dependent on us." A common reaction to this fear is to try to separate from the youngster too abruptly.

PRINCIPLES OF PREVENTIVE INTERVENTION AND TREATMENT

When a youngster is not developing the organization, initiative, or capacity for internalization which will form the basis for later representational capacities and higher levels of emotional experience, several approaches are necessary.

First, one must examine the environment. Are environmental responses either so unavailable or fragmented or overcontrolling and intrusive that they undermine the toddler's organization? If so, therapeutic approaches may be taken to correct the limitations in the primary caregivers and, if necessary, create an auxiliary support system to implement the missing experiences. Encouraging the involvement of other family members, as well as beginning a therapeutic relationship with the primary caregivers may be essential. Where emotional problems are not prominent, educative and modeling approaches may teach parents how to enter into organized behavioral patterns with their children. Parents may have particular difficulty if the child seems to be surpassing them in basic ability to organize complex behavior. Where this is the case, a combined therapeutic and didactic approach can be most useful.

PHOTO BY BARBARA HADLEY

One must also study the youngster's contribution to a disorder along physical, cognitive, and affective-social developmental lines. Earlier difficulties may be emerging. The youngster who never had a secure attachment or who never formed differentiated causal relationships may now *not* be able to deal with complex environmental events. Preventive and remedial approaches must go back and try to integrate earlier missing experiences with the specific experiences that are pertinent to this developmental stage. For example, a youngster who not only fails to organize his behavior and take initiative but who also demonstrates only a shallow attachment to his primary caretakers may need a great deal of physical care, holding, and soothing, with a primary focus on establishing trust and regularity. These activities must be combined with an attempt to develop new, more organized behavior, since the goal is to integrate the tasks of earlier developmental stages with the new tasks on the ascendancy.

SPECIFIC APPROACHES

The major specific intervention principle could be summarized under the term **integration**. In earlier stages of development, to diagnose interferences in contingent or reciprocal interaction patterns was essential. Now, assuming earlier stages have gone as expected, it is essential to diagnose what interferences in the youngster and the environment are preventing them from operating in a more integrated way. The child must now integrate complicated sensory and motor schemes, the affective polarities of life (loving, dependent, assertive, and independent responses), a wider range of social relationships (including relating to mother and father as different individuals rather than simply as replacements of one another) and, within these relationships, the different affective domains mentioned above.

As indicated under the discussion of general principles above, diagnosis of the negotiation achieved in earlier stages of development is the first step to intervention. The therapeutic plan must include capacities that are missing—but always in the context of the current level of maturation of the central nervous system and emerging capacities of the youngster.

If, for example, a child is able to play in a complex, organized way with a puzzle but is incapable of a rich, warm, affective contingent interaction with a person because of earlier difficulties in the stage of "somatopsychological differentiation," one should not necessarily hold and cuddle this youngster and play infantile games which would have been appropriate at 7 or 8 months of age. Rather one should perhaps do a puzzle with the child, taking advantage of his cognitive capacities while entering into clearcut causal or contingent social interactions and trying to "woo," to elicit a range of pleasurable affects and so forth. Earlier tasks are integrated with the phase appropriate capacities.

The second step is to focus on possible interferences in the youngster's capacity for integration. One must recognize the great variation in the rate of maturation among youngsters. The important issue, however, is not so much the rate of maturation, which will vary, but whether or not movement along progressive lines is occurring, and whether or not the most basic elements of the new capacities seem to be present.

When a youngster is not able on his own to integrate, the primary caretaker or others must create a setting which offers experiences likely to help the youngster integrate across various sensori-motor modalities and behavioral and affective systems. The child who does not integrate well on his own should be provided experiences where an activity is pursued with visual, auditory, and possibly tactile interactions.

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Mother and child can silently look at pictures in a book, for example, while mother turns the page and the toddler only looks. Alternatively, mother can combine the visual interest with auditory descriptions of the pictures. She can increase the range of behaviors or modalities involved further by periodically looking at the youngster and explaining what is in the picture.

PHOTO BY BRANDY JOHNSTONE

The youngster's receptive capacities are far greater than his language capacities at this point, and one might see the interested and eager child looking from the picture to the mother, hanging on her every word. Instead of turning the pages herself, mother can have the youngster turn the pages, offering a little help, thus enhancing the youngster's fine motor coordination. She may also have the child point out the different parts of the picture after she does, thus increasing imitative activity, initiative, and perceptual motor coordination.

Here, in a simple example, we can see how an exercise can be used in different ways. It can be used just as an exercise of the youngster's repeated experiences of visual interest, or as one which involves visual interest, auditory exchange, tactile stimulation, clear-cut social interchange involving vision, vocalization and meaningful contingent interaction, and fine motor and perceptual motor coordination. This latter approach obviously helps the youngster integrate across a range of sensorimotor modalities and affect systems.

It is sometimes easier to consider how to help the youngster integrate across sensorimotor modalities than it is to help him increase the range and integration of various social behaviors and affects of which he is capable.

By the middle of the second year, a youngster is capable of a range of emotions. If a child tends to be fragmented or to exhibit only a narrow range of affect or behavior (e.g., only negativistic; only interested in the inanimate world; only compliant, with mildly pleasurable responses but no assertive ones), the caretaker may be taught to follow the youngster's lead, waiting for the emergence of new affects and behavior, or to create occasions for the natural emergence of such new affects and behaviors. For example, the mother who tends to be overcontrolling in focusing the child on mastery and assertive activities, leaving little opportunity for pleasure and spontaneous discovery, can learn to "follow" the youngster's lead, waiting for the child to smile spontaneously (the "aha! experience") when discovering a new aspect of a toy.

On the other hand, a youngster may already be so rigidly locked into a pattern devoid of pleasure, spontaneity or joy that parents may have to experiment to create the opportunity for new emotion. As they and the youngster look at pictures together or explore a new toy, the parent may present the toy in a new position or try to get it to do something it would not ordinarily do or bring in a new toy to provide a novel experience. (The parent who always sits on a chair may get down on the floor, letting the youngster crawl over her to explore different aspects of their bodies together). The skilled clinician must be prepared to work with the caretaker and the child to encourage experimentation until new affects and behaviors spontaneously come into evidence.

One cannot force pleasure, but one can create the opportunities for it. Once the youngster shows the spark of enthusiasm, we guide the parent to show admiration and interest in this new affect. As assertive and exploratory behavior become enlarged to include pleasure as well, we observe the goal of this developmental stage—integration across a number of domains.

In similar fashion, we can help parents of a child who tends to be negativistic and whining offer experiences that are soothing, followed by pleasurable experiences. One youngster who tended to be fretful and negativistic would become noticeably relaxed when certain rhythmic music was played and mother would take him by the hand and begin a modified damce. The two would then relax, and spontaneous joy would occur in the context of the dance. Mother was not a musical person, and it had never occurred to her that this would be one way to soothe her toddler, who no longer responded to being picked up and rocked.

Initiative and originality also require support. The increased imitative activity and the original behavioral patterns one expects to see during this stage of development will occur quite naturally if the clinician has helped the caretaker create a warm, basically pleasurable relationship and an atmosphere where pleasure and excitement occur in some balance with other emotions. This will be the fertile soil for the natural inclinations of the youngster to imitate and create his own experiments. When the child does not take the initiative, the clinician should help the caretaker to wait until the youngster does take the lead and to create opportunities and novel experiences where possible. A very passive toddler may sit and look at, but not reach for, an interesting new toy. The toy may first have to be placed within his reach, then put a foot or two away, etc. Once the youngster sees the inherent pleasure in pursuing and taking initiative, this capacity can be enlarged.

In their eagerness to teach their youngster how to speak, walk, not touch things, etc., some caretakers do so much for and to the child that he never learns to take the initiative. A skillful clinician may teach such parents that the conscious goals they have for their child will more likely be reached by following the youngster's lead, being a good audience and partner rather than only a good director.

PHOTO BY FAITH BOWLUS

Another important therapeutic principle at this stage involves the balance between following the youngster and setting limits. The child who at 14 or 15 months is showing impulsive behavior (biting) or negativistic behavior (not cooperating) but little positive initiative, originality, pleasure, or compassion provides an unusual challenge. Providing experiences which afford pleasurable opportunities and understanding how the environment may be covertly contributing to the youngster's negativism is pivotal. Providing structure and setting limits in a highly systematic manner is also important. Engaging the youngster directly around his impulsivity, including physical holding and other restrictions when necessary, will help the youngster organize what he cannot organize for himself and convince him of the primary caretaker's interest. Firm limit-setting keeps the youngster from simply repeating the more regressive disorganized patterns not appropriate for this age.

This is an example of the direct application of the principle of providing opportunities for an integrated range of emotions. Where the youngster skews in one direction, opportunities for the other emotional patterns must be created. Each time one wishes to take away one mode of behavior, one should at the same time be offering the youngster an opportunity for a more sophisticated means of engaging and interacting.

When parents, possibly thought-disordered, lack the very capacity for organizing, comprehensive psychiatric care, including medication, structure, and support must be considered. Where character constrictions make certain types of affects frightening, or affects in general are frightening to the parents, psychotherapy might be warranted. While a psychotherapeutic experience to increase the range of affect tolerated ordinarily takes a great deal of time, a focused therapeutic effort may often be accomplished effectively in a more limited period. Parents who become aware that the child's assertiveness or pleasure seeking or separation behaviors cause them anxiety may learn to tolerate these behaviors in their offspring and remain available to them, rather than withdrawing from the threatening affects. Their special motivation to facilitate their child's growth and development may give them increased flexibility where their child is concerned, even though fears persist in other areas of life.

If working with the primary caretaker is not possible, working with other family members who have a greater range of available effects and a greater tolerance for the youngster's developmentally emerging capacities may be appropriate. Mobilizing siblings, a father, an available and caring grandmother, or a good day care program should all be considered as part of the therapeutic planning effort. The goal is to provide support for the child's emerging capacities, with the recognition of the importance of his relationship to his primary caretaker. While other adults may assume supportive roles, the primacy of the main character should never be ignored, nor should efforts to work with the primary dyadic relationship ever be put in a secondary position.

At times, the limitations in the caretaking milieu not only have to do with the individual family members, but with the family as a system. Individuals may be able to support, on a dyadic basis, overall developmental patterns towards greater organization, initiative and originality, but when the family is together as a unit, fragmented, disorganized communication systems prevail that lead to undermining behaviors on the part of family members. Here a family, extended family, or systems approach may be useful for understanding how these patterns operate.

EXTERNAL STRESSES

Whatever the developmental level of the child, one should never ignore the concrete needs and acute economic, social or medical stresses a family is facing. Even optimal individual and family capacities can be disrupted if the stresses are great enough. Concern with subtle affective issues in the caretaking environment should not blind one to acute issues such as problems with housing, food or medical care which may be undermining the natural strengths individuals and families may have at their disposal.

In sum, therapeutic principles at this phase of development should focus on the goals that the toddler must achieve: greater behavioral organization, initiative, and originality. Diagnosis should explore interferences in the child's development. Preventive intervention strategies must strengthen the toddler's capacity to integrate sensory and motor schema across domains, to integrate different emotions, and to learn to take initiative.

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Clinical Illustration:
MRS. M. AND HOLLY

The following case material also comes from Stanley I. Greenspan's ***Psychopathology and Adaptation in Infancy: Principles of Clinical Diagnosis and Preventive Intervention*****. The family described came to the attention of the Clinical Infant Development Program when Mrs. M. experienced difficulty with her toddler and expressed interest in "learning more about child care."**

Mrs. M. presented as superficially competent although further clinical investigation suggested the presence of an underlying chronic thought disorder, and she was able to function reasonably well when not under stress. When Holly, a constitutionally sound little girl, was born, Mrs. M. responded positively. While her initial involvement had a "play-acting" quality, Mrs. M. nevertheless attended to the physical needs of her infant, provided adequate protection, and engaged in a somewhat satisfying attachment. Also, when not under pressure—and fortunately, her life circumstances were such that she was not under acute external pressure—Mrs. M. was able to read her baby's signals and support Holly through the stage of differentiation. Mrs. M. maintained the relationship with her therapist begun earlier and responded well to support and structure when she experienced occasional lapses in reality testing or disorientation in thinking.

MRS. M: FEARS AND FANTASIES

Themes which emerged in the therapeutic work included Mrs. M.'s concerns about her own body and her fears and fantasies that her growing infant would develop "a defect." Mrs. M.'s associations to this defect usually want to "bone cancer," "leukemia," or other "injuries." The image that emerged was one of some amorphous cancer distorting the rather distinguished features of Mrs. M.'s quite pretty litte girl.

As long as discussions stayed fairly simple, organized, and structured, Mrs. M.'s reality orientation and capacity to organize her thinking did not become too disrupted. Only when Mrs. M.'s feelings toward her husband or older daughter (who was already having considerable cognitive and behavioral difficulties) became complex (e.g., feeling ambivalent) did her thinking become disorganized.

Mrs. M. seemed to enjoy her closeness with her new infant and the fact that Holly could also supply her with direct feedback. Little Holly was a good responder and offered mother predictable reciprocal interaction patterns which, paradoxically, helped her mother organize herself.

When Holly began to enter the stage of "behavioral organization, initiative, and internalization," she began to demonstrate a wider range of emotions, a deeper sense of affiliation and love, and more organized anger, protest and jealousy of her older sister and her mother than had previously been the case. Holly was also beginning to organize her behavior and to imitate the complex interaction patterns she had observed between Mr. and Mrs. M. or between her parents and her older sister. When Holly began doing *new things* that were not familiar to Mrs. M., Mrs. M. became particularly disturbed and began to demonstrate the thought disorder previously not in evidence.

HOLLY: THE "LITTLE BOSS"

By this time, Holly was able to walk; she enjoyed being "the little boss," in charge of herself and coming to and going from mother as she wished. While Mrs. M. verbalized joy and pleasure in the new abilities and greater autonomy of her confident toddler, at the emotional level Mrs. M. became disorganized every time she talked about Holly's development. Somatic, delusional thinking began to emerge as Mrs. M. complained, "I think there is a hole in my chest. My blood is running out."

During a home visit, we noted that when communication was simple, when Holly sat on her mother's lap and let her mother hold her or said a word which mother could answer, Mrs. M. seemed organized. When Holly put demands on her mother to interact in a complicated game, however, or when she demonstrated organized feelings either of jealousy or affiliation and love (e.g., when she ran to father and hugged him and made other loving gestures toward him) we noticed mother become, first, diffuse in her thinking and then tangential, going off on themes related to physical illness. Particularly difficult for mother to handle was Holly's ability to do precisely what was age-appropriate—to relate to mother and father and older sister all at once, in an integrated pattern. Holly could walk around and begin communication with each figure in the room, bringing a block first to father, then to the clinical worker, then going over and trying to engage her older sister, and finally returning and also showing some affection for her mother.

NEW DEMANDS, NEW STRESSES

This degree of complexity seemed to stress Mrs. M. and result in further disorganization. For example, Mrs. M. might talk about how Holly had said a new word and then, as she watched Holly negotiate a complex behavioral pattern, begin suddenly to talk about a person she had read about who had cancer. At these moments, Mrs. M.'s affect became flattened and she became more impersonal. We reasoned that, added to the specific dynamic implications of Holly's ability to be more separate and apparently able to organize more effectively than her mother (thus stirring up some envy), in a more general sense Holly was reaching a stage of emotional behavioral organization that somehow was more complicated than Mrs. M. could handle. Just as Mrs. M. had previously demonstrated the tendency to become disorganized in her therapy sessions if the themes became too complicated, here to, when her daughter offered her more complex and rich themes (which were age-appropriate for Holly), Mrs. M. seemed to become overwhelmed.

The therapy sessions tried to focus on this more general issue of how disorganized Mrs. M. felt at times and what types of experiences were associated with this disorganization, especially as it related to her daughter. At first, the subject of disorganization was itself disorganizing. As Mrs. M.'s disorganization continued, we noticed her imaginative, curious, innovative daughter begin to regress. By fifteen months, Holly began vacillating between extreme negativistic behavior and fragmented aggressive behavior (e.g., she would run up to her older sister and bite and kick). Periods of organized, rich, innovative, and imaginative behavior remained, but they were becoming less frequent, while negativism and aggresive, more fragmented patterns were beginning to dominate.

USE OF THE INFANT CENTER

Although Holly's father could engage her, he came home from work too late to be available for help. Holly's older sister was having too many emotional and cognitive problems of her own to be supportive. At this point, we began involving Mrs. M. and Holly at our Infant Center, where other adults were available to help Mrs. M. support the child's emerging behavioral organization, initiative, and capacity for innovative new behaviors.

We were amazed to see Holly reverse these regressive patterns within two weeks, with the help of other available adults and the presence of her mother. In the Center we could also watch Mrs. M. and Holly interact with each other for longer periods of time than at home, observe at what point Mrs. M. disorganized, and then reflect together on what seemed to be happening.

Gradually, we developed a program which helped Mrs. M. focus on exactly what had occurred. When she and her daughter played together, we would intercede as soon as Mrs. M. disorganized. At first, Mrs. M. would be unable to understand what had happened. Often she misperceived what had occurred—she interpreted assertive behavior as aggressive or independent behavior as abandoning. With immediate structure and feedback, however, Mrs. M. began slowly to understand some of her daughter's more complicated behavior. At the same time, in her own therapy sessions, Mrs. M. was able to grasp more fully the implications of her tendency to deal with emotional complexity with disorganization.

As this work continues, Mrs. M. is now able to support her daughter's continued development at home, and Holly has resumed an optimal developmental course. Although Mrs. M. still tends to disorganize with complex emotion, she has learned enough about her daughter's behavior so that the unfamiliar has itself become familiar and what was formerly complex for her is now more clearly understood and thus less difficult to deal with. We expect that Mrs. M.'s difficulties will continue as Holly develops further. But Mrs. M. now realizes that *she* can learn from her daughter.

For Your Information:

Family Resource Coalition—at last spring's Family Resource Forum, hosted by Family Focus (see **Zero to Three**, Vol. I, #1) in Chicago, groundwork was laid for the establishment of a national coalition of family resource programs. The new Family Resource Coalition will operate as a loose federation of state-wide and province-wide organizations and will be sponsored initially by Family Focus. Coalition functions will include information sharing, technical assistance, the development of a research knowledge base, public education, and advocacy.

For further information, write to: Family Resource Coalition, Family Focus, Inc., 2300 Green Bay Road, Evanston, IL 60201.

Child Welfare Grants to States—HHS Assistant Secretary for Human Development Services Dorcas Hardy has granted a total of $2.2 million to states to "aid in planning and implementing child welfare services during a time of Federal-State transition." Each state and territory has designated a public or non-profit agency engaged in research or child welfare activities to receive grants and design projects, which will last one year or less and may be narrowly or broadly construed.

The agencies designated by the states are likely to be in the midst of project planning as this is written. To learn the name of your state's designee, write or call Teresa Hawkes, Director, Office of Program Coordination and Review, OHDS, DHHS, Room 307-E, Humphrey Building, Washington, D.C. 20201, tel: (202) 245-7027.

Call for Papers—The First International Conference on Pediatric Social Work will examine "Current Controversies in Pediatric Social Services" from August 12-15, 1982 in Chicago, under the sponsorship of the Eterna International Foundation for Disabled Children. Proposals for papers and presentations may be sent to Allen F. Johnson, Conference Chairman, 6 South Terrace, Auburn MA 01501.

Point of View:

A PHYSICIAN'S REFLECTION ON PUBLIC LAW 94-142 (THE EDUCATION FOR ALL HANDICAPPED CHILDREN ACT) AND ON ITS IMPLICATIONS FOR HEALTH AND MENTAL HEALTH PLANNING FOR INFANTS

by Saro Palmeri, M.D.

Saro Palmeri, a pediatrician, is Assistant Clinical Professor at the Yale Child Study Center and Director of the Child Development Program of the Connecticut State Department of Health Services. Dr. Palmeri's views are personal and may not necessarily reflect those of the Connecticut State Department of Health Services.

Since its passage in 1975, the Education for All Handicapped Children Act (Public Law 94-142) has given renewed impetus to special education in this country at the federal, state and local levels. It has also stimulated a great deal of interest in the medical and allied professional community. That the Act emerged from the 1981 Congressional budget process unaltered, independent of any block grant (though the amount of its appropriation is still uncertain as of this writing) indicates the Act's political popularity as well.

Yet professionals who support P.L. 94-142's intention that no handicapped child be deprived of an education commensurate to his or her adaptive abilities and that early intervention measures be used to place a child in the "least restrictive" educational environment possible may nevertheless question the wisdom of applying the educational model of P.L. 94-142 to the needs of children under three years of age.

In drafting this legislation, we must recall, Congress had in mind school-age children with organic handicaps, serious emotional disturbances, and specific learning disabilities. P.L. 94-142 required Local Educational Agencies (LEA's) to identify such children and, with parental participation, plan for their education. Using funds from local, state, and federal sources, LEAs are to educate all handicapped school-age children, regardless of income. Many states have extended this mandate for educational planning to handicapped children as young as three, while a few begin at birth.

In contrast, health and mental health public resources for children of all ages lag behind public educational resources. No well-organized health care system, private or public, is available to children at all socio-economic levels. Indeed, the private health care system, including private health insurance, is more prevalent than federal and state programs, which are inadequately funded, spotty in coverage, and categorically restricted.

It is not surprising that under a law designed to *educate* the handicapped, health issues are subordinated to educational issues and medical expertise is subjected to educational authority. Unfortunately, without input from health and mental health professionals, educational authorities may plan educational objectives and strategies for a child while giving inadequate attention to medical needs, both physical and mental, and overall development. And when children from birth to three years are involved, this imbalance can have severe consequences.

Let us begin from the premise that, developmentally, preschool children have needs different from school age children and adolescents. The handicap most common among very young children, educationally as well as medically, is a "delay" in one or more areas of development, most commonly in language development. Most developmental delays in this age group are mild and the milder the delay, the more likely it is to be the result of experiential factors.

Furthermore, unlike the disabilities (sensory, motor, cognitive, or psychosocial) of older handicapped children, which are a good deal more discrete, the disabilities of very young children are more often than not in the making, and often the result of a combination or organic and experiential factors. A given set of factors may lead to any one of several kinds of developmental pathology, including, but not limited to, some form of learning disability.

The younger child differs from school-age children also in his or her dependence on the family for a nurturing environment which will foster attachment, personality growth, and physical, cognitive, emotional and social adaptation. Handicaps, developmental disabilities and delays become part of family life and cannot be seen in isolation. The more handicapped, developmentally disabled or delayed the child is, the greater his or her dependency on the adults of the family and the greater the impact of the handicap on the family. Health, mental health, and social agencies have traditionally been better (if not adequately) equipped than the educational system to deal with developmental and family problems. Except where extreme forms of neglect and physical or sexual abuse threaten the very existence of the child, it behooves society to safeguard those nurturing ties while helping the family and the handicapped child to overcome their difficulties. For many children under three or even five years of age, the "least restrictive environment" is the home.

Because they reflect the rapidly changing quantitative and qualitative characteristics of the development of pre-school children, especially those under three, in all areas of development, developmental services are especially appropriate to very young children. Yet while P.L. 94-142 quite appropriately requires psychological services for school-age children, no mention is made of *developmental services* for younger children. And although developmental terminology already shared by medical/pediatric, allied medical, educational professionals and parents alike could easily form the basis for a common language, which would facilitate implementation of the law, the expertise of clinical child development specialists, which does not result in psychological "scores," is often challenged.

I would suggest that a careful and comprehensive medical-developmental scrutiny must precede educational intervention with very young children. Educational intervention should occur only after health professionals with developmental knowledge have discharged their responsibility in terms of identification, health and developmental planning, and monitoring. And by developmental scrutiny I do not mean a series of discrete evaluations from speech pathology, physical therapy, occupational therapy, psychology, etc. under the aegis of Local Educational Agencies and limited to educational objectives, but a full developmental understanding under clinical developmental supervision, for there is more to a developmental disturbance than cognitive delay alone. It is also important that, recognizing the rights of parents to be an integral part of planning for their child, professionals have some opportunity to discuss developmental issues which should be only carefully shared with parents and certainly not discussed at open educational planning meetings.

I have argued that clinical developmental experts ought to assume the initial responsibility for clinical scrutiny of potentially handicapped children. Unfortunately, not enough medical and allied health experts in clinical child development exist to do this job on a national scale. But is this shortage a justification for abdicating a principle and a responsibility? Just as physicians and other clinical experts ought not to replace educators in their mission, the latter ought not to displace the former in their crucial role.

Many deserving and valiant educational efforts funded by educational agencies do try to meet the special needs of troubled families and their handicapped and delayed children. But should "education of the handicapped," currently a popular and favored national task, displace what is already in place and is legitimately a health and mental health task? Should education assume the clinical role for the handicapped of this nation? How much wiser it would be to promote a health/developmental/educational continuum model, where those valiant educational efforts can be better utilized after, and in concert with, organized and comprehensive clinical effort. The problem lies in timing, comprehensiveness, and funding. Clinical judgment and planning ought to precede educational efforts—which may then become entirely appropriate.

What is good and appropriate for school-age children and adolescents may not be wise for infants and children. Let clinical pediatric and health programs direct identification efforts and therapeutic services—both adequately funded—designed to meet clinical developmental needs.

National Center Notes:

by Eleanor S. Szanton

The National Center takes pleasure in announcing a new publication series: **Clinical Infant Reports**. This will consist of works of a longer, more detailed nature than can be included in **Zero to Three**. Designed to improve the daily work, training, and professional expertise of practitioners, this series will publish reports of empirical and developmental research; clinical case studies; practical program descriptions; clinical studies relating to diagnosis, prevention, and treatment; and reports of conferences relevant to issues in clinical practice.

Clinical Infant Reports will be edited by Sally Provence, Editor of NCCIP Publications, and by an Editorial Advisory Board whose members are Peter Blos, Jr., T. Berry Brazelton, Selma Fraiberg, Stanley I. Greenspan, Peter B. Neubauer, and Leon J. Yarrow. Published by International Universities Press, volumes will appear once or twice a year.

The first volume of **Clinical Infant Reports**, available in December, is **Psychopathology and Adaptation in Infancy and Early Childhood: Principles of Clinical Diagnosis and Preventive Intervention** by Stanley I. Greenspan. Excerpts of the book are featured in this issue of **Zero to Three**. All **Zero to Three** readers will receive a special mailing about the series, including ordering information.

The number of responses to our **Training Institute** on **Indicators of Mental Health Disturbances in the First Eighteen Months of Life** has been very satisfying. We are pleased that Dr. Herbert Pardes, Director of the National Institute of Mental Health, will deliver the Plenary Address.

Zero to Three has moved from zero to one year old. Please remember to resubscribe! And since many of our new subscribers learn of this publication by word of mouth, sending in a copy of a colleague's subscription blank, please mention **Zero to Three** to your associates who might find it interesting and useful.

THE COUNCIL FOR CHILDREN AND FAMILIES: A PROGRAM OF ADVOCACY IN CHITTENDON COUNTY, VERMONT

by Paul C. Young, M.D.
Chairperson, Council for Children and Families

Janet S. Munt, ACSW
Director, Community Child Protection Network

Chittenden County, Vermont is home to 120,000 people, or more than one quarter of the state's population. Forty-five thousand people live in Burlington, the state's major city and the cultural and economic center of Vermont.

The Visiting Nurses Association has had a maternal and child health program providing services to newborns and their families since the 1920's. Currently, about seventy expectant mothers or newborns at risk are referred monthly for early intervention services. Last year the referral rate represented approximately 29% of babies born in the county and a very high percentage of those infants at risk for developmental difficulties or maladaptive parent-child relationships such as child abuse and neglect.

"A small population is both a blessing and a curse," says Janet Munt, director of the Community Child Protection Network. "We can clearly identify people in need, but we do not have the resources to provide necessary services unless we reorder our priorities and put preventive services at the top of the list."

In 1978, the publicly mandated child protection agency and five private agencies providing direct services to children and families—all chronically overloaded by service demands and all in competition to some extent for scarce resources—formed a consortium and applied for and received a three-year community based Service Improvement Grant from the National Center on Child Abuse and Neglect. The paper, "Parent Education as a Therapeutic Intervention," available from the Network, describes one of the expanded preventive services for young children and their families made possible by the grant.

The article below reports on the citizens' advocacy effort which was brought into being by the Network professionals. Recognizing that institutional failures were frequently producing or aggravating problems of families and children, they decided to encourage a group of concerned citizens to take active responsibility for trying to improve the community's response to child maltreatment.

Convinced that professionals have an obligation to do administrative advocacy to secure, enhance or develop existing rights, services or resources, the six agencies which had formed the Community Child Protection Network in 1978 a year later proposed a citizens' council to act as advocates for children and families. Agency representatives judged it important that advocates be spokesmen with no professional self-interest at stake. Accordingly, the Council membership was recruited primarily from Chittenden County citizens who had demonstrated personal and professional interest in child and family issues but who were not themselves providers of services. Those invited believed in the Network's principles and values and were committed to broad-based community efforts.

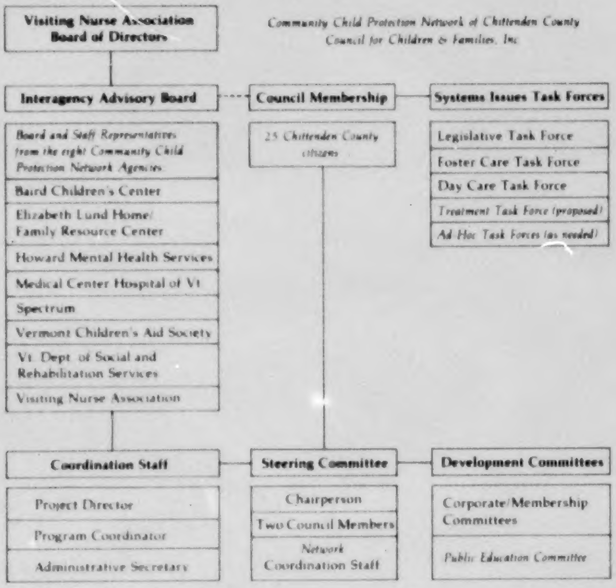
The Vermont Secretary of Human Services was informed of the establishment of this advocacy group and asked to name her deputy, a Chittenden County resident, to work with the Council. She did so. Other members include a former governor and his wife, who had always been actively involved in human service issues; the county coroner, who had been deeply affected by her experiences with the victims of child abuse at its most severe; an administrator in the city school system; several university professors, one of whom, George Albee, has national stature in the field of prevention; a police chief; and lawyers, bankers, and businessmen. A pediatrician was selected as Chairperson.

The goals of the Council, established in 1980, were:
- to assess the current system of child protection resources in the county and in the state;
- to outline a comprehensive system of community prevention and treatment services that would effectively address problems of child maltreatment;
- to increase public awareness and education through the dissemination of information about child abuse and neglect; and
- to advocate public policies and resources that would improve the availability and delivery of services to children and families.

The Council for Children and Families, composed of interested citizens and staffed by the Director and Project Coordinator of the Child Protection Network, recognized the need to set priorities for action, yet to act on several fronts at once. Council members chose to direct their efforts outside the service delivery system, toward the top level of state administration—the Commission of Social and Rehabilitation Services, the Secretary of Human Services, and ultimately the Governor and Legislature—while the Network pressed for improvements within the delivery system. The Council's two staff members and a part-time administrative secretary worked with both the Network and the Council to provide coordination between the two groups as well as with other multi-disciplinary components of the Child Protection Network (see chart).

COUNCIL FOR CHILDREN AND FAMILIES OF CHITTENDEN COUNTY

— Organizational Chart —


Visiting Nurse Association Board of Directors
Community Child Protection Network of Chittenden County
Council for Children & Families, Inc
Interagency Advisory Board
Board and Staff Representatives from the eight Community Child Protection Network Agencies
Baird Children's Center
Elizabeth Lund Home/ Family Resource Center
Howard Mental Health Services
Medical Center Hospital of Vt
Spectrum
Vermont Children's Aid Society
Vt. Dept. of Social and Rehabilitation Services
Visiting Nurse Association
Council Membership
25 Chittenden County citizens
Systems Issues Task Forces
Legislative Task Force
Foster Care Task Force
Day Care Task Force
Treatment Task Force (proposed)
Ad Hoc Task Forces (as needed)
Coordination Staff
Project Director
Program Coordinator
Administrative Secretary
Steering Committee
Chairperson
Two Council Members
Network Coordination Staff
Development Committees
Corporate/Membership Committees
Public Education Committee

COUNCIL "PRODUCTS"

The Council addressed four "systems" problems identified by the Network. The first was the need for more complete and refined child protection statutes, clearer definitions of child abuse and neglect, sanction for multi-disciplinary child protection teams, and shared responsibility for the complex social problem called child abuse/neglect. A task force of Council members, Network representatives, and other professionals drafted a new child abuse statute. In what was to become a model for the Council's work, Council members on the task force drew on professionals for self-education as they drafted the statute and in the process became heavily invested in the fate of their creation.

Introduced in the legislature in 1981, the draft statute unanimously passed the House but was stalemated in the Senate. Prospects are good for passage in 1982.

After careful data collection and research, the second Council task force developed a position paper on foster care which was sent to the Governor, key legislators, and administrators of state government. New foster care regulations reflect several of the Council's recommendations, and the state agency agrees to other if funds are available. Pressure from the third Council task force helped to preserve state funding for day care for children at risk for abuse or neglect, even though state support for employment-related day care is threatened with elimination.

Perhaps most importantly, the Commissioner of Social and Rehabilitation Services has invited the Council to participate in drawing up a comprehensive state plan for child welfare services before the next legislative session.

The Council's next position paper will address the fourth systemic problem: treatment services for children and families with maladaptive relationships. We need to look at the consequences of many current practices: what happens when would-be consumers of supportive and preventive services such as day care are required to undergo "treatment" as part of the package, or when we attempt to provide psychotherapy for unmotivated "patients" whose most urgently felt needs are social, and beyond local resources to meet? We hope to convince the legislature that if we put our energy, skill and money into support services and early intervention measures that would be available, without stigma, to all parents and children, we would greatly reduce the need for later, costly, treatment and rehabilitative services.

FUTURE OF THE COUNCIL

The Council for Children and Families has accomplished enough of its original goals in the first fifteen months to convince members that its continued existence is important at this time in our community. The Council has already become incorporated and taken steps to become an independent, tax-exempt membership organization. We hope that by organizing a membership campaign we can not only raise sufficient funds to continue our efforts but also create in our community a greater sense of responsibility for the problem of child abuse and neglect.

Once established as a membership organization, the Council will continue to monitor all state and local legislation that affects children and familes and develop position papers on the most important bills. We will continue to work with other advocacy groups in this area and to keep the day care and foster care task forces active. We intend to have impact on the setting of block grant priorities through our legislative task force. With a vigorous fund-raising effort among citizens, businesses, and industry we plan ultimately to develop a Children's Trust Fund to serve as a source of support for towns, school systems, and private or public agencies which wish to develop primary prevention programs.

If there is merit in the "new Federalism" it must ie in the fact that it requires an informed, compassionate citizenry willing not only to pay for but to become actively involved in the resolution of its social problems.

Publications:

BOOKS

Infant Caregiving: A Design for Training—Alice S. Honig and J. Ronald Lally (Syracuse, NY: Syracuse University Press, 1981) $12.95.

As the authors of **Infant Caregiving** point out, this new edition comes at a time of urgent national need for quality group care for children under the age of three.

Committed to the premise that "infants flourish when special people are sensitive to them and can meet their needs," Honig and Lally have designed this book as a resource for those who *train* such "special people." Individual chapters deal with infants' emotional development, nutrition, large-muscle and small-muscle skills, sensory experiences and language growth. Chapters deal not only with what is known about infants but with effective ways of teaching caregivers to make use of this knowledge.

A chapter new to this edition discusses special topics such as care of infants under five months of age; better communication with infants and parents; integrating handicapped or abused infants into a program; infant sexuality; and assessment of caregivers' skills.

An extensive annotated bibliography includes books, articles, manuals and audiovisual materials.

Working with Parents and Infants: An Interactional Approach—Rose Bromwich, with contributions by Dorothea Burge and Ellen Khoka (Baltimore, MD: University Park Press, 1981) $19.95.

The Intervention Program of the UCLA Infant Studies Project, chronicled in this volume, was based on the proposition that mutually satisfying interactions between parent and infant establish the foundation for optimal development of the infant. The Program attempted to enhance the quality of parent-infant interactions through a process of education and intervention designed to increase parents' competence and confidence in themselves as the primary agents of change for their infants.

Working with Parents and Infants describes the UCLA Program's theoretical framework; presents an assessment tool, the Parent Behavior Progression; and discusses at length both specific problems in parenting and the modes of intervention and staff responses found effective. In addition, the book presents in detail the thirty cases which constituted the intervention population—both cases in which intervention was judged successful and those in which intervention failed to achieve or achieved only partially major program goals are analyzed.

Bromwich concludes that two factors were chief predictors of intervention effectiveness: the priority of the infant in the life of the parent who functioned as primary caregiver and the degree of parental concern about the infant's current and future development.

PERIODICALS

Child Welfare Planning Notes (published monthly by the CWLA Hecht Institute for State Child Welfare Planning, 1346 Connecticut Avenue NW, Washington, D.C. 20036) $48 per year.

As of September, 1981, the Child Welfare League of America has changed both the format and the content (but not the color) of its "green sheet." While pledging to continue to report timely news from Capitol Hill, *Planning Notes* editors intend to expand coverage of states and localities.

The process of setting funding priorities for children, new roles for business and voluntary efforts, the fate of program monitoring, and the effect of budget cuts are issues to be discussed in coming months.

The Federal Monitor (published six or more times per year by the Alliance for Perinatal Research and Services, 321 South Pitt St., Alexandria, VA 22314) $10 per year.

Now under new management, the four-year-old *Federal Monitor* will continue to cover legislative news concerning women's and family health, with an emphasis on childbirth. It is designed to report and follow up on Federal regulations, agency reports, relevant court decisions, and state actions and to direct readers to sources of information and services.

PAMPHLETS

Family Day Care in the United States: Executive Summary—Patricia Divine-Hawkins (DHHS Publication No. [OHDS] 80-30287, Administration for Children, Youth and Families, U.S. Department of Health and Human Services, Washington, D.C. 20201, 1981)

Family day care homes provide services for nearly half the children in day care in the United States. Providers may operate informally, independent of any regulatory system; may meet state and/or federal standards and be licensed or registered; or may constitute part of a day care system or network sponsored by a social or educational agency.

The National Day Care Home Study, a four-year undertaking sponsored by the Day Care Division of the Administration for Children, Youth and Families examined family day care providers, the children in their care, the children's parents, and day care costs and administrative structures. This Executive Summary outlines the study's findings.

The Final Report Series of the National Day Care Home Study includes seven volumes of findings and analyses as well as manuals designed for day care systems and family day care providers, all prepared by Abt Associates and SRI International. All reports are available from the Administration for Children, Youth and Families or from ERIC Document Reproduction Service, P.O. 190, Arlington, VA 22210.

A NON-PUBLICATION

When Congress postponed the effective date of the HHS Day Care Regulations in December, 1980, it directed the Department of Health and Human Services to conduct a comprehensive assessment of current day care practices in the states.

The study was completed and submitted to Secretary Schweiker this summer, and its findings have been made available on inquiry. The Secretary, however, has neither submitted the study to the Congress nor published it.

The finding most relevant to **Zero to Three** readers may be that many more day care centers across the country exceed HHS staffing requirements for children age two or older than fail to meet them. But among centers serving children under age two, many more *fail* to meet HHS staffing requirements than comply.

Readers wishing to obtain a copy of the study may first have to exert pressure to assure its publication. Writing to members of Congress and to the Honorable Richard Schweiker (DHHS, Washington, D.C. 20201) might help.

Conference Call:

January, 1982

January 30-February 6: *The Department of Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco* and *Extended Programs in Medical Education, University of California, San Francisco School of Medicine* will present a course on "Advances in Maternal and Fetal Medicine" in Park City, Utah for nurses and physicians. Lectures and round table discussions will cover topics in obstetrics, ob-anesthesia, genetics, ultra-sound, midwifery, infectious disease, and neonatology. For further information, contact Extended Programs in Medical Education, University of California, San Francisco, 1308 Third Avenue, San Francisco, CA 94143, tel: (415) 666-2894.

February, 1982

February 22-26: *The High/Scope Educational Research Foundation* will sponsor a one-week institute in Ypsilanti, MI, for teachers, program administrators, and others on "Supporting the Parent's Role in Education: Effective Parent Involvement in Preschool and Elementary Programs." Write to or call Ellen Lynn, Institute Coordinator, High/Scope Educational Research Foundation, 600 North River Street, Ypsilanti, MI 48197, tel: (313) 485-2000.

TIME TO RENEW!

Zero to Three

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CONFERENCE CALL

continued from previous page

February 25-27: *The American Academy of Pediatrics* will offer a CME course on "The Newborns in Your Practice" at the Royal Sonesta Hotel in New Orleans. Contact Judy C. Hambourger, Coordinator for Sponsored/Co-sponsored CME Courses, American Academy of Pediatrics, P.O. Box 1034, Evanston, IL 60204, tel: (800) 323-0797.

March, 1982

March 29-April 2: The 59th Annual Meeting of the *American Orthopsychiatric Association* in San Francisco will focus on the theme "Families: Rights, Needs and Services." Sessions dealing specifically with infants and their families include "Program for the High-Risk Pre-School Child" and "Support Programs for Families of the Very Young: Issues and Problems." To receive a preliminary meeting program, write or call American Orthopsychiatric Association, 1775 Broadway, New York, NY 10019, tel: (212) 586-5690.

March 18-21: *The International Conference on Infant Studies* will meet in Austin, Texas to discuss physiological, perceptive, cognitive, and social development as well as issues involving high risk infants. Write for information to Leslie Cohen, M.D., ICIS, Psychology Department, University of Texas, Austin, TX 78712.

April, 1982

April 14-16: *The Save the Children Child Care Support Center* in Atlanta, Georgia will sponsor "Family Day Care: A Technical Assistance Conference." Sessions will be addressed to a national audience of trainers, providers, licensing staff, policy makers, advocates and researchers. Contact Joe Perreault or Nancy Travis, Save the Children Child Care Support Center, 1182 West Peachtree St. NW, Suite 209, Atlanta, GA 30309, tel: (404) 885-1578.

April 28-30: *The NICU at Indiana University Medical Center's James Whitcomb Riley Hospital for Children* will sponsor a neonatal multidisciplinary conference on "The High Risk Family." The conference will include general sessions and workshops and feature Marshall Klaus and Morris Green as speakers. Write or call Rebecca Burks, 1100 West Michigan St., Riley Hospital —A302, Indianapolis, IN 46223, tel: (317) 264-2479.

April 16-17: *The University of Maryland School of Medicine Department of Psychiatry* and the *Maryland Institute for Child Study* will sponsor a conference on "Conceptual and Practical Clinical Work with Infants and Young Children" in Columbia, Maryland. T. Berry Brazelton will be a featured speaker. For information, write or call the Program of Continuing Education, University of Maryland School of Medicine, 10 South Pine Street, Baltimore, MD 21201, tel: (301) 528-3956.

Zero to Three

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Zero to Three

Bulletin of the
NATIONAL CENTER FOR CLINICAL INFANT PROGRAMS VOL. II, NO. 3 MARCH 1982

SELMA FRAIBERG: 1918-1981

Selma Fraiberg, professor of child psychoanalysis at the University of California in San Francisco, Director of the Infant Mental Health Program at San Francisco General Hospital, and a founder and active Board member of the National Center for Clinical Infant Programs, died of cancer in late December, 1981. She was 63 years old.

A clinician and teacher, Selma Fraiberg was also the author of many psychoanalytic papers and of *The Magic Years*, translated into 11 languages. Her interest in handicapped children and in studies of infancy is reflected in *Insights from the Blind* and *Every Child's Birthright*. *Clinical Studies in Infant Mental Health: The First Year of Life*, edited by Fraiberg, described the Child Development Project in Washtenaw County, Michigan, which she directed.

At its December Training Institute, the National Center presented its Dolley Madison award to Selma Fraiberg. The text of the award reads:

"Selma Fraiberg has superbly earned this honor, awarded in the name of the First Lady of this country who established the earliest services on this continent for children in developmental crises. In the scientific world related to children, Selma Fraiberg is unique in this century. Her insight into the needs and functioning of the very young, the handicapped, and their parents, crosses the disciplinary lines of the helping professions. Through her classic books, she has accomplished the rare feat of communicating directly, clearly, and understandably, yet without oversimplification.

Selma Fraiberg can think as babies do. Her magic has allowed us to know infants and young children more fully so that we, too, can help their families and guide them toward health and sound development. Her work is indelibly etched on our minds, a part of our basic knowledge and skills. She is a beloved scholar, child analyst, clinician, poet, and friend."

Selma Fraiberg's death, occurring at a time of great influence and productivity as a clinician, teacher, and writer, is a very great loss. We sorrow deeply for ourselves and for the field of endeavor we shared with her.

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National Center for Clinical Infant Programs *733 15th St., N.W., Suite 912, Washington, D.C. 20005* *(202) 347-0308*

REPORT FROM THE SECOND TRAINING INSTITUTE
THEME AND VARIATIONS

by Peter B. Neubauer, Albert J. Solnit, and Sally Provence

In its Second Training Institute, the National Center for Clinical Infant Programs undertook to study the first eighteen months of infant development after birth. We wished to look particularly closely at indicators of mental health and earliest developmental deviations, and at the process of translating diagnostic and classification skills into appropriate techniques of preventive treatment.

As our Institute announcement noted, careful clinical evaluation of disturbance in mental health and physical development in infancy is the best tool we have for planning effective treatment and preventive programs.

In the first 18 months of life the indicators of healthy and deviant development are always expressed and observed in the context of the infant's care by an adult, usually a parent, without whom the infant could not live. As Freud put it in his 1926 paper on the problem of anxiety:

"The biological factor is the long period of time during which the young of the human species is in a condition of helplessness and dependence. Its intrauterine existence seems to be short in a comparison to that of most animals, and it is sent into the world in a less finished state. As a result, the influence of the real external world upon it is intensified and an early differentiation between the ego and the id is promoted. Moreover, the dangers of the external world have a greater importance for it, so that the value of the object which can alone protect it against them and take the place of its former intrauterine life is enormously enhanced. The biological factor then establishes the earliest situations of danger and creates the need to be loved which will accompany the child through the rest of its life." (Freud, standard edition, pp. 154-155, 1926)

During the last twenty years, researchers and clinicians have learned a great deal about physical and neurological maturation, about the unfolding and subtlety of interpersonal patterns between infant and caretaker, and about affective and cognitive development and related coping strategies. Yet comprehensive clinical assessment, which attends simultaneously the multiple clinically relevant areas of human function, remains a challenge both to the professional in the clinic and the researcher in the laboratory. We hoped that the Training Institute would illustrate how practice informs theory and how theory guides practice.

The program reflected the interdependence of research and practice, of evaluation and treatment, and of assessment and counseling in the service of children and their families in the first months of life. With a format including both panel presentations and small workshops, the faculty could share their knowledge and discuss the questions currently intriguing them while the registrants, through active participation, helped the faculty to learn as much as it taught.

The 1,000 participants brought a richness of experience and a passion of concern about young children that set the tone for the overall program. As we had anticipated, a variety of professionals attended the Institute. Some were practitioners working with acute problems, some with more chronic conditions. Some were beginners; many were quite experienced. Some were especially interested in research and its applications, others more concerned with developing greater

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effectiveness in the systems of delivery of mental health services for the very young and their parents.

Federal government awareness of the importance of infancy was reflected in two plenary addresses by Edward N. Brandt, Jr., M.D., Assistant Secretary of Health, DHHS and Herbert Pardes, M.D., Director of the National Institute of Mental Health. Brandt cited the National Center's ability to hold fast to its original concept of strengthening science and the practice of mental health care for infants and young children. After reviewing the current work of NIMH in children's mental health and infancy research, Pardes indicated NIMH's commitment to foster increased understanding of early childhood disorders in relation to later behavior and to continue a major focus on the developmental approach to health and mental illness.

We cannot attempt in this article to summarize the Training Institute in any complete or comprehensive way. Instead we will select some broad themes and some special highlights from an impressively rich array of presentations and workshop discussions in the hope that these selections will capture some of the content, the excitement, and the spirit of the occasion.

The study of infancy is the study of multiple and interacting variables. As faculty members and participants in the Training Institute discussed their diagnostic work, treatment approaches, and research, it was evident that they assign high relevance to some data and less to others. In a complex field, researchers may have to hold some information in limbo (but not forgotten) until its significance can be understood. What any one clinician might select as relevant diagnostic data depends on that clinician's view of the data's explanatory power in understanding the disorders of infancy and usefulness in developing therapeutic plans for the improvement of an infant's functioning.

Using significant data, one hopes to expand and refine a theory. An integrated clinical developmental approach to understanding the mental health needs and disorders of infancy is not yet a unitary theory and may not become one in the near future. Nevertheless, every practitioner implicitly or explicitly, more or less systematically, uses certain clinical constructs derived from theory and practice. Linking theory closely to empirical findings is one way to develop such clinical constructs. And the interaction of clinical data and theoretical assumptions, the constant examination of one against the other, provides important guidelines for practice.

Certain unique characteristics of infants influence diagnosis, and failure to keep in mind these characteristics results in a failure to understand the infants themselves.

- The younger the child, the more likely he is to react to adversity with global responses and symptoms rather than more focussed or differentiated ones. This tendency reflects the closeness of the psychic and somatic systems in infancy.
- A situation of adversity in the young child's experience is highly likely to disturb or cause delay in more than one area of development. It also causes trouble in the organization and integration of those functions.

David Toerge

Stanley Greenspan addresses Institute.

By adversity we mean such conditions as maternal depression or a chaotic environment which not only fails to provide the infant with positive experiences but subjects him to a succession of negative ones. An older child who has had reasonably good care and has developed well up to the point of a traumatic event or difficult situation will also react, of course, but because of greater maturation, differentiation and integration of functions, he will have more differentiated or structuralized reactions and possess a more extensive repertory of defenses and coping abilities than the infant.

- Some infants are more inherently vulnerable than others to psychosocial stress; some not so vulnerable biologically may nevertheless be at risk for disorders of development because of adverse experiences. When biological vulnerability and an adverse psychosocial environment are found together, the conditions that produce disturbance in the child are maximized.

Biologic circumstances such as prematurity, traumatic birth, primary mental subnormality, or sensory defects like blindness or deafness, when combined with problems in the nurturing environment, are especially hazardous for the developmental process and for behavioral organization. Such combinations often lead to psychopathology.

With these principles as a foundation, four major themes emerged in the Training Institute that reflect aspects of the state of the art of clinical work with infants and their families.

Continued on following page

The first theme, repeated in variation throughout the presentations and workshops, reminds us that both theory and practice are crucially dependent on direct observation of infants and of infant-parent interactions. Such observations, difficult though it sometimes is to make sense of them, provide indispensible data for diagnosis when added to the information gained through interviews and through a more traditional medical assessment. While observation is useful to the assessment of developmental and mental health disorders at any age, it is of supreme importance when children are very young. Many presenters stressed the usefulness of close observation and described the various methods of observation they use. Especially effective were videotapes illustrating mother-infant interaction—particularly some of the subtleties of mutual cueing or its absence.

A second theme, perhaps the major one of the "sonata," recognizes that evaluation in the first eighteen months of life is both a diagnostic process and an effective first step in intervention.

Keenly aware of this linkage, professionals in a wide range of settings have designed infant-parent interactional assessments to foster a therapeutic alliance between parent and investigator. As the alliance forms, the parent is able to give a more valid history, while the investigator can work to uncover nuances of harmony and dissonance, synchrony and dysynchrony, continuity and discontinuity in the infant-parent relationship.

A third theme, illustrated as much by the form of the presentations as their context, asserts that the study of individual cases is still one of the most important methods of doing research and training.

Presenters' detailed reports of individual children and their families, eloquently described and often recorded on videotape, inspired the audience and evoked an outpouring of comments, questions, and rich case material from participants during workshop sessions.

A fourth theme involved the recognition that in the field of infant mental health and development, video and other technological devices now serve, rather than dominate, our studies, evaluations, and interventions.

The first three panel presentations of the Training Institute focussed on:

- Principles of evaluation and assessment in the first eighteen months of life (Sally Provence [chair], T. Berry Brazelton, Stanley Greenspan, and Leon Yarrow);
- Evaluation for counseling and consultation with parents (Peter Neubauer [chair], Kathryn Barnard, Elsie Broussard, and John Kennell); and
- Evaluation for in-depth comprehensive treatment (Reginald Lourie [chair], Peter Blos, Jr., Eleanor Galenson, Robert Nover, and Serena Wieder).

Presentations offered differing but not incompatible approaches to assessment, described the integration of assessment and therapeutic work with parents in a variety of settings, and illustrated the ways in which evaluation remains an integral component of long-term

In panel presentations and in many of the 25 workshops, videotapes illustrated vividly aspects of diagnosis and intervention.

David Toerge

David Toerge

T. Berry Brazelton and Frederick Green (at right of table) lead workshop on primary health care.

treatment. Readers may wish to review the articles by Yarrow and Brazelton in **Zero to Three** (March, 1981 and September, 1981) and to consult the National Center's first **Clinical Infant Report**, Greenspan's *Psychopathology and Adaptation in Infancy and Early Childhood: Principles of Diagnosis and Preventive Intervention* (see p. 15 for order form).

Workshop sessions following each of the panels dealt with basic research, primary care, clinical mental health applications, public health and public policy, and child and parent education, Participants and leaders stayed together for three two-hour sessions. A review of the reports of workshops revealed a broad array of interests and research and clinical experience and a free exchange of ideas. Evaluation questionnaires returned by participants show that despite differences in experience, sophistication and focus of the daily work, workshop discussions were stimulating, useful, and appropriate.

The final plenary session on research and its implications for clinical assessment illustrated the themes of the Training Institute with particular clarity. Under Albert Solnit's chairmanship, the session included Mary Ainsworth's presentation of "Infant Attachment and Maternal Care," Robert Emde's "Using Emotions in Infancy," and Daniel Stern's "Parent-Child Interaction: Instant Replay."

Mary Ainsworth used findings from an intensive naturalistic study supplemented by observations in a controlled laboratory situation to report and examine the nature of the attachment of the infant to mother at the end of the first year.

Interpreting the findings, Ainsworth suggested that the main feature of maternal behavior associated with an infant's "secure attachment" was the mother's sensitive response to her child's signals across all important contexts of their interaction. Ainsworth found that the anxious-avoidant" infant attachment pattern was associated with maternal aversion to close bodily contact.

Demonstrating the relationship between these studies and the development of hypotheses, Ainsworth proposed that mother-avoidant behavior under stress results from a severe approach-avoidance conflict about close bodily contact, with avoidant behavior representing a defensive maneuver of the young child, who tends to exclude from awareness the perception of environmental clues that might activate both attachment behavior and intense anger. Directly relevant for clinical work, Ainsworth's research data are congenial with observations made by clinicians working with infants and parents in whom conflicted, ambivalent attitudes toward the infant lead to nurturing deficits and consequent disturbances in the mother-infant relationship. In extreme cases the mother's avoidance of close bodily contact with the infant serves as a protection of the child against physical abuse.

Robert Emde's presentation emphasized his view of emotions as a "language" in infancy. He pointed out that "not only do infant emotions provide crucial signals for caregiving and social activity, but they also lead to feelings in the sensitive clinician which guide assessment and intervention."

Continued on following page

David Toerge

More than one thousand participants attended the Second Training Institute.

Using videotapes, Emde illustrated recent research findings which document that the infant seeks emotional information from the mother's face in situations of uncertainty or conflict and guides his behavior accordingly. The importance of the mother's availability at such times has been persuasively documented. But Emde reported that the infant searches for emotional signals from others besides his mother. Emde placed his observations in a theoretical framework that includes the concept of the biologically prepackaged, species-specific capacity to communicate. The signaling system is encoded in the infant and is decoded by the responsive, tuned-in adult.

Daniel Stern illustrated and discussed the use of immediate television replay of parent-child interaction as a research and, potentially, a therapeutic tool.

He recounted how in the course of his experiments on infant memory for actual life events he had shown mothers TV replays immediately after interaction with their child. Stern and his colleagues noted that a sensitive clinician looking at the tape with the mother could help her to reflect upon her behavior and that of the infant, thereby increasing understanding of what might be going on between them. Stern pointed out that this is not a new technique, that particularly careful attention must be paid to how the technique is used, and that the problems in its use concern knowing what questions to ask and which theoretical issues inform the choice of questions.

Using taped sequences from his research, he illustrated these points and shared with the audience the way in which he would think with the parent about the significance and usefulness of the observations. Stern also discussed issues regarding the contributions of research to the welfare of the subjects, indicating that participation in sensitively conducted research can be experienced by a mother as a major investment in her, an indicator that she is worthwhile. At the same time, Stern emphasized that other parents, especially those from deprived socioeconomic groups, might feel they are being experimented upon and exploited.

The National Center's training institutes have several goals. The first is to present illustrations of current knowledge and its pursuit through research and clinical work, updating knowledge as much as possible. The Programs are shaped, or at least strongly influenced, by the knowledge and beliefs of the faculty and those who attend. Some selectivity is clearly at work, and some of the content could be called "propaganda of importance."

Beyond the content, and perhaps more significant in the long run, are the stimulation and inspirational value generated by the interaction of all the participants. We believe that the National Center's Second Training Institute helped to reaffirm our sense of a community of interest and concern for infants and their parents and to increase opportunities for continuing communication and shared work.

National Center Notes:

by Eleanor S. Szanton

The great event to report to you since the last issue of **Zero to Three** is our Second Training Institute, which many of our readers were able to attend. Drs. Neubauer, Solnit and Provence have provided a summary of the meetings, particularly the large panels. It remains to summarize who was there, what they thought about it, and how it "felt."

More than 1,000 people attended the Institute from 45 states, Canada, and 4 foreign countries. In order to keep workshops to manageable size, we had to turn away some potential registrants. Participants represented, once again, the full range of disciplines which form our constituency, with more than 200 psychologists of various kinds, well over 100 psychiatrists, nurses, and social workers, and close to 100 pediatricians and educators.

The overwhelming impression of the faculty and leadership of the National Center was that this was a highly experienced, well-trained group, sophisticated in their work, who brought as much to the conference as they took away from it.

Since the evaluations of our first Institute had left us with the sense that too much time had been spent in large meetings, this Institute was organized to permit a great deal of small group interchange in workshop meetings spread out over the two days. A faculty of 52 leaders in the field made this possible. I had a chance to sit in on almost all the workshops for a short period of time. I was excited by the depth of discussion as leaders and participants exchanged clinical material and ideas.

In an effort to provide ourselves with information from the participants that would help us to evaluate the Institute, we asked registrants to return a questionnaire. While we cannot know about those who did not return the form, of those who did, 75% thought the conference was at their level, and 90% learned from the Institute and found it useful. More than 85% of respondents in education, day care, social work, psychology, nursing, pediatrics, and psychiatry valued the experience highly. Respondents ranked the panel presentations highest in value and also showed strong support for the workshops and pre-conference seminars on assessment and funding.

Our ability to serve so many disciplines continues to gratify us and to mirror, we feel, the multidisciplinary spirit of professionals in the field itself.

Participants voiced a strong interest in the possibility of regional institutes and workshops in other parts of the country. This interest echos the National Center's concern to provide an impetus for activity *throughout* the United States. We know that many people could not come to the Training Institute in Washington because of the large travel expenses added to the cost of the conference, and we will explore the idea of regional institutes with potential funding sources.

Only 48 participants identified themselves as working in rural programs, and we found this disappointing. We know that some of the greatest challenges to ensuring adequate infant mental health and development exist in rural areas and, also, that a number of programs have devised creative outreach and resource sharing approaches in order to serve rural families. If you, as a reader, know of rural programs that might not know about us but which would be interested in the National Center's publications or future training activities, please let us know.

At its last meeting the Board of Trustees of the National Center set up a Committee on Research to take initiatives in the coordination of research around issues of clinical prevention and intervention with infants and families. To this end, we have funded a survey of the literature on evaluations of early intervention programs from which we will develop an analysis of the effectiveness, cost effectiveness and cost benefit of such programs. We expect this study, which will collect available data using sophisticated statistical techniques and combine data across studies, will make a contribution to programs, to policymakers and to third party payers and purchasers of insurance. We believe it will identify further the essential value of early intervention to children, families, and society.

As states and localities begin to feel the impact of last year's budget cuts and ponder the implications of "the new federalism", advocates for children are collecting data, planning strategies, and looking for ways to work with human services coalitions at the local, state, regional, and national levels.

Accurate, detailed information is crucial to the process of talking with legislators and administrators. If your program is suffering cuts in its budget, please let us know:

- the number of infants and families you have been serving
- the nature of your service
- sources of funding and the amount and/or percentages of funds cut
- and, most of all, the impact of cuts—reduction in caseload, limits on services, staff layoffs, etc.

Please let us know, also, of public education, coalition building, or lobbying efforts that have enabled you to maintain or expand services to infants and their families. Your experiences may be very helpful to colleagues in other communities.

While we can't help you with much-needed funding, we can be helpful in dramatizing what is happening in our field.

Case Report:

RESULTS OF A MISMATCH

by Audrey Naylor, MSW
Child Development Unit
Yale Child Study Center
New Haven, Connecticut

Mental health professionals are, in general, committed to preserving the family unit that seeks their help, usually an appropriate goal. This case report suggests that a "divorce" between parents and child is sometimes in the best interests of all. That mental health professionals in a clinic might assist parents in a voluntary decision to relinquish their child is, in principle, an acceptable role. And yet such cases, when presented to colleagues, are met in our experience with heated argument and dismay and the suggestion that if the professionals were more skillful or had tried harder the family could have been preserved.

Goldstein, Freud and Solnit (1979), discussing parental requests to place a child have proposed a legal ground designed to ". . . provide parents with a relatively stigma-free and non-violent opportunity to invoke the child placement process. Its purpose is to maximize every unwanted child's chances of being placed in a family that wants him." (p. 33-34) They point out also that the fact that some parents might want to give up responsibility for their child runs counter to society's wishful thinking that a parent's love will endure, making it difficult to give recognition to the reality.

This case report also illustrates that professionals need perceptiveness and flexibility in order to understand the communications, in words and behavior, of their patients. Moreover, clinicians have a responsibility both to the parents and to the child, once a decision is reached, to help them work out both the logistics of the new placement and their complex feelings about it with a minimum of destructiveness.

—Sally Provence, Editor

Amy, age 19 months, was the daughter of Mr. and Mrs. L., a 28 year old couple who had adopted her in another state before moving to Connecticut. When Mrs. L. telephoned the Child Development Unit, she urgently requested an emergency appointment saying, "We've reached the limit of our ability to cope with Amy." She had been placed in their home at the age of 5 weeks, a physically healthy but "ugly" baby. In contrast to experience with their son Tom, now 3½ and also adopted in early infancy, Mrs. L. said they had had nothing but grief with Amy.

Mr. and Mrs. L.

Seen first without Amy, Mr. and Mrs. L. brought up the following concerns: As a very young infant Amy had been irritable and could not be cuddled or rocked. She was frightened of her bath. By the time she was 5 months old she began waking at night and screaming. Then the "screaming fits" began occurring both day and night. Recently they had become worse, more frequent and prolonged, sometimes lasting as long as three hours. The parents had never been able to stop the episodes once started. Any slight disciplinary action or a frustration such as getting a pull toy caught on something could precipitate an episode. There was at times no known precipitant.

The parents also reported being concerned in general about Amy's development. She had only three words and did not use them communicatively. It had been very hard to know what she wanted because she gave neither verbal nor nonverbal cues. Amy was hyperactive and fell frequently, often from bumping into things. She seemed to have no normal response to pain, either from falling or from more serious injuries. Once she sat down on the coals of a campfire and was badly burned but didn't cry. She always ate voraciously but had no awareness of being full. Rocking and head banging, though still occurring, were less frequent now than formerly. Amy was said not to play with toys and not to accept parental help to play. She was, the parents felt, unresponsive to them and uninfluenced by any action of theirs. She did not imitate them, try to please them or accept comfort from them. Amy did not smile or show any affection. Much of the time she didn't look at them.

Given the parents' report, the clinical team expected to see a child with a severe personality disturbance and perhaps one with complicating neurological abnormalities. The frequent falling and unawareness of her body's body's place in space might well be due to psychological disturbance. But the child's failure to react to what would normally be felt as severe pain was more ominous if the campfire episode had been accurately observed and reported.

Amy

The child seen for diagnosis resembled very little the child the parents described, but she was nevertheless a child in trouble. Throughout the procedures, including developmental testing and diagnostic play sessions, she remained sober, unsmiling, muted in response. Results of testing with the Yale Developmental Schedules were remarkabily age appropriate. Her gross and fine motor skills were average for her age, and she was not hyperactive or even overactive. Though she failed two language items, she had scattered successes in language and problem-solving items at 21 and 24 months and several problem-solving successes at 30 months. However, she found no pleasure in either test or play materials. Her attention to toys was fleeting. She seemed to ask permission for every move she made and often appeared frightened. Contrary to the parents' report, Amy reacted sharpl to their disapproval during the testing sessions. Several times she seemed to be asking for a favorable signal from her mother, but Mrs. L. did not respond. Once when Amy bumped her head and once when she fell of a chair, she showed awareness of pain but her reaction was fleeting and neither parent offered comfort.

Barbara Young

A Working Hypothesis

Impressions of Mr. and Mrs. L. were based on their behavior during the diagnostic appointments with Amy and on what was learned from their own appointments during the evaluation. Putting together all data about bot parents and child at the end of the diagnostic study, staff developed the following working hypothesis. It was likely that Amy was at birth an unusually sensitive infant predisposed to anxiety and perhaps experiencing some kind of physiologic discomfort. Since the screaming episodes did not start until age 5 months, they were likely due not only nor primarily to Amy's particular vulnerability but to parental response to her. Certainly at present there was no evidence of neurological abnormality, no disturbance in motor skills, no hyperactivity and no absence of pain awareness. There was, however, reason to think that Amy's carelessness of her own safety and her minimal response to pain were psychologically determined. Further, the therapeutic plan to be proposed was based on the overall impression that the etiology of Amy's disturbance rested *primarily* in current and past abnormalities in the nurturing environment. Only a trial of treatment, it was thought, would determine the extend of her innate personality disturbance.

A Therapeutic Trial with the Ls'

The plan proposed to the Ls was for their own appointments at weekly intervals to continue and for Amy to be seen twice weekly by a separate therapist. The Ls accepted the plan on the basis of their professed wish for help in dealing with Amy and hope for therapy to change her. The therapists were whole-heartedly committed to the task ahead but aware that it would be difficult. The Ls' anger at Amy was intense. Mrs. L. mentioned having once been able to stop the screaming episode with one of her "I-could-kill-you looks." She spoke with pleasure, as if triumphantly scoring over an adversary in a contest. Mrs. L. talked of fearing she would abuse Amy, though she insisted she never had. Both parents were extremely rigid and strict with Amy, expecting behavior far in advance of her age. In addition, Mrs. L. was experiencing chronic severe headaches and was depressed, fatigued and quite out of touch with her own feelings.

Early in the therapeutic trial the work was complicated by Mr. L.'s insistence on hospitalizing Amy "to find out what's wrong with her" and by the family pediatrician's insistence that Amy's problems were due to a milk allergy. The timing of the hospital study was unfortunate but it was not possible to influence that decision in discussions with the pediatrician and parents. The contact with Amy and her parents was resumed when the results of an extensive hospital study were negative. It may be that Mr. L. was enabled to participate more fully in the work because he had been satisfied that the basis of Amy's disturbance was not physical.

Mrs. L.'s lack of hopefulness about Amy's therapy was expressed in a contemptuous attitude toward the child's therapist, an attitude that play therapy was just permissiveness. Perhaps reflected also was hopelessness about herself. She was very open, though without appropriate affect, about fear of abusing Amy, adding now that she wasn't as upset about it as she used to be because she loved Amy less every time she had one of her "screaming fits, like an animal."

> *"The child seen for diagnosis resembled very little the child the parents described, but she was nevertheless a child in trouble. Throughout the diagnostic sessions she remained sober, unsmiling, muted in response."*

Mrs. L. expressed growing doubt that she could become the kind of mother that Amy needed. She said, "I've told other people that maybe Amy needs somebody else . . . she needs a chance to be normal and maybe I

CASE REPORT, *Continued on following page*

can't give her that." Mrs. L. used therapy hours mainly to express such fears and doubts, to complain about Amy's behavior and in so doing, to cite examples of the child's response to what both parents saw as reasonable ways of dealing with a child of less than two years. For example, if Amy either refused or was denied a particular food and screamed, she was sent to her room. If, on returning, she again refused food or made any disturbance at the table she was told she would have no more food the rest of the day.

Amy's Response to Treatment

Amy responded to treatment with important changes within the first six weeks.

On one occasion her therapist recorded, "Amy used lots of language today and became very animated. The contrast between how she arrived—disorganized, dazed, and restive—and the way she emerged as energetic, alert, interested and able to take pleasure in her activities was more striking than ever before."

Initially Amy's play had been extremely inhibited and cautious, but even after it became more free, a footstep in the hall outside the treatment room could bring a stricken look to her face and an anxious question, "Mommy?" Gains made in treatment were seen also in a re-evaluation at age 24 months. Though Amy was emerging as a delightful and highly competent child with a capacity for normal relationships, at home she continued about as before, and Mrs. L. continued both complaining about Amy and doubting her own ability to be the mother Amy needed.

The Decision to Relinquish Amy

The repetitive nature of the parents' material in therapy and their inability to move into an examination of their relationship to Amy prompted the clinical team to give special attention to the possibility that the Ls were seriously asking to be relieved of the child. As the material from all sources was brought together and discussed in a case conference, the growing impression that the Ls seemed to be asking to be freed of trying to be Amy's parents was supported. The conference dealt also with the troubled feelings of the therapists, declining hopefulness of progress toward the initial goals but reluctance to "hear" the persistent messages from Mrs. L. More about the disturbance of each parent than can be given in a brief report was included in the deliberations and added further clinical substance to the decisions with which the conference ended: that it was likely Amy could become a wanted child of new parents, that Mr. and Mrs. L. might thus be relieved of unhappiness and lack of satisfaction in their role as Amy's parents and that the parents' therapist needed to respond to the implicit and often explicit theme of giving Amy up in order to help the parents reach a decision.

Once the possibility of relinquishment was the focus of interviews, Mrs. L. could allow the self-examination not possible when improving her relationship to Amy was the ostensible goal. Over a period of two months very painful but fruitful work was done by both parents, resulting in a decision to relinquish Amy, one that was mainly Mrs. L.'s but in which Mr. L. concurred. There was no evidence that adoption was a factor either in the parents' feelings and behavior toward Amy or in their decision, though it is possible that had she been their biological child, their responses might have been different.

"Mrs. L. seemed to know—as the clinical team did not, initially—that she could not change. But she managed to control impulses toward physical abuse that would have brought her quick relief from the child and to free both herself and Amy from misery."

It should be emphasized, lest the case material convey a different impression, that Mr. and Mrs. L. behaved in a responsible way. It became clear that Mrs. L. could *not* engage in a process that might relieve her of the psychological problems underlying her reactions to Amy. She seemed to know—as the clinical team did not initially—that she could not change, but she managed to free both herself and Amy from misery, while controlling impulses toward physical abuse that would have brought her quick relief from the child.

The decision, with which the clinical team concurred, was based on Mrs. L.'s awareness of what she termed "a force within her" that would not permit her to care for Amy in a nurturing way. She experienced a brief mourning reaction but was mainly relieved to relinquish Amy. Mr. L.'s reaction was more painful, but Mrs. L. unexpectedly was able to help him with his feelings. She was also able to use suggestions for helping their son with his reactions to separation from Amy. Interviews with the Ls continued for two months after Amy's move to a new adoptive home. The goal of helping them arrive at a decision without devastating guilt and conflict appeared to have been achieved. Three months after termination Mrs. L. telephoned to report that things were going well for the family.

Helping Amy and Her New Parents

A major part of the work remained, that of helping Amy, now 26 months old, and her new parents. It was made easier because of a close, cooperative relationship with the adoption agency responsible for assisting in Amy's new placement. The Bs, a couple with no children, carefully chosen to be her new parents, accepted a proposal that Amy continue with her therapist during a period of adjustment to her new home and that they have access to a staff member who knew Amy well but had not worked with the Ls.

Barbara Hadley

During the period of removal and placement, Amy was able to use her therapist as a source of reassurance. She used language and play very well to express her worries and needs. She was skillful at evoking from her therapist explanations about what was happening to her. Making up and singing songs to Amy became a particularly useful way for her therapist to give some kinds of information and make some feelings explicit. Requesting a song then became one of Amy's main ways of asking for an explanation or clarification. As Amy found more security and satisfactions in her new home, the therapeutic contact became, appropriately, less intense.

Work With the Adoptive Family

The work with the Bs was unusually gratifying because of their intuitive responses to Amy. Very quickly they discerned from her reactions that such things as putting her thumb in her mouth or spilling her milk had been considered major "crimes." They stressed how easy it was to know what she needed or wanted. "She tells us in so many ways."

On a few occasions Amy started to scream but could be helped to stop almost immediately. Once when she resisted giving up a potentially dangerous tool and a bit of a struggle started, the screaming stopped when Mrs. B. simply said, "I think we both need to calm down." Amy did.

Understandably, Amy was also struggling to preserve her own identity. When the Bs began to feel some security with Amy and affection for her, they once addressed her as "Sweetheart." Her response was to become troubled and to insist she was not "Sweetheart" but Amy, a name the Bs had wisely allowed her to keep in spite of some concern about its making her more easily identifiable by the Ls and their friends.

When Amy finally began to feel safe with her new parents, she revealed both her fear of going back to her first home and her wish not to be reminded of it. A doll Mrs. L. had considered a favorite was sent with Amy to the Bs. Twice Amy lost it and twice it was restored to her by Mrs. B., who then asked at clinic whether she should continue to find it for Amy. As anticipated, the doll was lost a third time and this time it was allowed to remain lost. On an occasion when Mrs. B. and Amy had gone on an errand, Mrs. B. said, "Now we'll go home." Amy became very upset. Thinking this must mean her previous home to Amy, Mrs. B. added, "We're going to *our* house." Amy smiled in relief. Once at the clinic she happened to see the Ls' therapist. She became quite upset and could not be easily reassured. Amy spent a restless night, but in the morning, on being held and again reassured that she was going to stay where she was, she finally smiled and said, "No more old Mommy."

Conclusion

Six months after Amy's treatment began and two months after her placement with the Bs, the clinic appointments were terminated. The treatment and the move to a nurturing home had answered the question about the extent of innate personality disturbance in Amy. If she had been a highly anxious and sensitive newborn, she nevertheless had strong recuperative powers which could operate once chronic stress was reduced and conditions of good care were provided. A follow up a year after termination revealed that the adoption had become final, that Amy was developing well in all visible ways, and that her parents were delighted with her.

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Goldstein, J., Freud, A. and Solnit, A.J. (1979), *Before the Best Interest of the Child.* New York: The Free Press, pp. 33-34.

PARAVERBAL THERAPY WITH ADOLESCENT MOTHERS AND THEIR CHILDREN

by Evelyn Phillips Heimlich
Associate Consultant in Medical Psychology
Associate Staff in Psychiatry
St. Luke's Hospital, New York City

Paraverbal (para = beside) psychotherapy is a method of observation, diagnosis, and treatment that places a special reliance upon sensori-motor systems, rather than words, for communication. In the Adolescent Mother-Child Clinic of St. Luke's Hospital, New York City, I have used paraverbal psychotherapy techniques with adolescent mothers, who tend, as a group, to talk to their babies less than older mothers and who may have difficulty communicating with their infants on other levels as well. My goal has been to foster attachment and developmentally appropriate behavior in both mother and child.

The setting for paraverbal psychotherapy should allow physical closeness between mother and child and encourage touch. Simple percussion instruments, elastic rope, finger paints, balls, soap bubbles and similar materials are used in an experience designed to be pleasurable for participants and free of stress.

The therapist encourages, accepts, and elaborates upon the patient's own rhythmic patterns, vocalizations, movements, and dramatizations. She can quickly substitute one medium for another in order to maintain attention and provide the pleasure that accompanies novelty. Using her voice, face, gestures and body movement, the therapist also becomes a model for expressive behavior.

The child acquires a greater awareness of his body's capabilities as well as a sense of mastery from using drums, hoops, and other materials. In reciprocal events, like imitative tapping or mime, he learns to wait his turn. When the therapist improvises lyrics to describe the activities taking place, the child can begin to link words and actions.

The following material illustrates a typical paraverbal session.

THE FAMILY

Elena, a plump, depressed, Hispanic 16-year-old, carries her infant daughter Rosa in a canvas bag on her chest. At eight months, Rosa is tiny and unusually quiet. Her brother, Julio, is three and one-half years old, physically well-developed, hyperactive, and verbally limited.

THE SETTING

The 14′ × 19′ room is bright, with squares of carpeting on the floor placed so that seated participants can touch each other easily. At the therapist's side are attractive percussion and stringed instruments as well as a circular elastic rope, balls, soap bubbles, and a hula-hoop. A table, chairs, record player, and easel complete the equipment.

LONG-TERM GOALS

- To develop communication and attachment between the adolescent mother and her children.
- To foster age-appropriate behavior in mother and children.

SHORT-TERM GOALS

- To provide a mutually nurturing experience for mother and children.
- To provide a model of structured, purposeful behavior for mother and son.

THE SESSION

The therapist gently places a plastic circle of wristbells in Julio's hands and closes his fingers over the circle to help him maintain his grasp. She gives another wristbell circle to the mother. Guiding them with a minimum of talk, the therapist begins chanting, "Pulling, pulling, back and forth." The therapist grasps each of the circles that mother and child hold and rocks back and forth with them. Her aim is to encourage pleasure in kinesthetic stimulation and the feeling of safety and trust which can be attained from synchronous, rhythmic body movement. As the group works together, Julio begins to smile.

To maintain interest and to reinforce their pleasure, the therapist introduces a new tempo. With excitement in her voice, she says, "Now let's pull fast, very fast." Both mother and child laugh as they enjoy a new synchronous experience. After several elaborations on this exercise, the therapist makes a point of praising Elena for the skillful manner in which she works with her son and Julio for his own efforts. Elena smiles at the recognition.

The rhythmic pulling back and forth are designed to promote the boy's impluse control and to harness his hyperactivity. Bodily experiences of the words up and down, back and forth, slow and fast, are introduced to help develop his language ability, while the tactile experience itself may provide nurturance to both mother and child.

The therapist now places an elastic rope around mother, son, and herself. She shows them how to place their hands on the rope and encourages them to imitate her movement as she sways and chants, "Pulling,

pulling, pulling in a circle." Elena and Julio show pleasure as their bodies touch.

After another similar activity, the therapist for the first time mentions the baby by name and actively includes her. She improvises lyrics about Elena, Julio and Rosa. Both mother and son look towards Rosa when the therapist introduces her name. When the therapist deliberately includes the baby in the event by placing wristbells in front of her, Elena spontaneously picks up the bells, shakes them at the baby, and is delighted when the baby reaches for them. The therapist then gives additional wristbells to mother and son so that they can accompany her while she plays and describes what they are doing in song. During the chanting, the baby spontaneously turns over on her belly, jiggles the bells, and crawls toward the group. Julio pats her on the head. Elena smiles.

To develop the feeling of mutual relatedness and intimacy, the therapist picks up Rosa, puts her in the center of the group, and has everyone take hands to form a circle swaying around the baby. She starts to chant, "Here we are together, all sitting on the floor. We're singing, we're smiling, we're looking at the baby." Rosa begins to coo, and Julio says, "She's talking. She's smiling." His mother nods.

It is time for the session to end. The therapist stands up and chants, "Good-bye, everybody; come again; it is nice to play with you; come again." Elena picks up the baby and dresses her while the therapist helps Julio with his jacket. When the therapist sings, "Come again," Julio asks, "When?" His mother smiles. The therapist opens the door and says, "See you next Wednesday!"

REFERENCES

For further information on the role of sensori-motor experience in child development, mother-infant communication, and the theory and technique of paraverbal psychotherapy, readers may consult the following publications:

Frank, L.K., "Tactile Communication," in *The Rhetoric of Nonverbal Communication*, H.A. Bosmajian, ed. (Glenview, IL: Scott Foresman and Co., 1971).

Phipps-Yonas, S., "Teenage Pregnancy and Motherhood: A Review of the Literature," American Journal of Orthopsychiatry, Volume 50, #3, 1980.

Sandler, J., "Background of Safety," International Journal of Psychoanalysis, Volume 41, 1960.

Stern, D., "The Goal and Structure of Mother-Infant Play," in *The Origins of Behavior*, Volume 2, M. Lewis and L. Rosenblum, eds. (New York: John Wiley and Sons, 1974).

Publications:

Publications from the December, 1981 Training Institute

In response to many requests for published material based on the December, 1981 Training Institute, the Editorial Board of the National Center for Clinical Infant Programs proposes to publish another volume in its series, Clinical Infant Reports, which will address the topic "Mental Health Disturbances in the First Eighteen Months of Life." It will incorporate material presented at the Training Institute and materials which examine other appropriate aspects of the topic. This volume is intended to cover many elements of the subject more systematically than could be done in a large meeting.

Publication is tentatively scheduled for Fall, 1982.

BOOKS

Day Care: Scientific and Social Policy Issues—Edward F. Zigler and Elmund W. Gordon, editors (Boston, MA: Auburn House Publishing Company, 1982) $24.95 cloth, $12.95 soft cover.

This book includes reports of recent research on the effects of day care, critiques of that research, and policy analyses on the delivery of day care. Contributors have backgrounds in experimental psychology, early childhood education, psychoanalysis, economics, pediatrics, public health, and politics—Edward Kennedy and Orrin Hatch join Sally Provence, Edward Zigler, Julius Richmond and other day care researchers and policymakers.

Infant day care receives special emphasis in articles focusing on theoretical and social science issues related to day care. Several authors demonstrate that the practical application of psychoanalytic principles can result in day care experiences with long-term benefits to infants, as in the Yale Child Welfare Research Program. But other writers remind us that relatively few infants enjoy the high quality of care available in the university-based centers most likely to be studied; inconsistent caregivers may contribute to developental problems.

A major theme of the book is the continuing debate over quality and cost—what one author calls the "day care stalemate" and another "the dilemma of affordable child care." Zigler and Gordon note that they are aware that this volume offers "no simple or single solution to the nation's day care problems" but hope that the book will clarify the complexity of the issues and suggest some policy directions.

Continued on following page

REPORTS

A Children's Defense Budget: An Analysis of the President's Budget and Children (Publications Department, Children's Defense Fund, 1520 New Hampshire Ave., N.W., Washington, D.C. 20036), $10.50.

Sent to the printer's only days after the unveiling of the President's 1983 budget proposal, this 200-page document provides a national overview of how, program by program, administration-planned budget cuts will affect children. The volume also includes a "Children's Survival Bill"—an altenative budget that gives high priority to children's needs and allocates national resources accordingly. A section on "myths and realities" analyzes Administration positions on funding for children's programs and suggests arguments for the child advocate.

Early Intervention for Children with Special Needs and their Families: Findings and Recommendations—Garland, Stone, Swanson and Woodruff (WESTAR, Product Dissemination, University District Building, 1107 N.E. 45th, Suite 915, Seattle, WA 98105) $2—checks payable to the University of Washington.

This 40-page paper was researched and written by members of INTER-ACT, the National Committee for Services to Very Young Children with Special Needs and their Families (see Conference Call, page 16) and is being distributed by WESTAR, the Western States Technical Assistance Resource.

Noting that while the national commitment to older handicapped children has grown, the commitment to the needs of handicapped children aged birth to three years and their families has remained disproportionately small, the paper attempts to document the need for, and the cost effectiveness of, early intervention.

The paper's four sections describe:

- research demonstrating the effectiveness of intervention programs and their impact on the development of very young children and on infants and toddlers at risk
- the effect of services on the family and the rationale for family participation in programs for very young handicapped and at-risk children
- data on the costs and cost-effectiveness of intervention programs for children from birth to three and
- characteristics of a comprehensive service delivery system.

One Step at a Time—Barbara Scheiber (Closer Look, Parents' Campaign for Handicapped Children and Youth Box 1492, Washington, DC 20013, 1981).

Closer Look, a national information and resource center for disabled people, has designed this 35-page booklet for parents of handicapped children or parents who suspect that all is not well with their baby.

One Step at a Time focuses on the period from birth through early childhood. It describes developmental sequences, emphasizes the importance of early intervention, and guides parents in working as partners with professionals on behalf of their children. Books and other materials on early learning, child development, and some specific handicapping conditions are listed, as are national organizations that can help parents.

PERIODICALS

Infant Mental Health Journal: Special Issue (International Association for Infant Mental Health [IAIMH], 110 W. Downie, Alma, MI 48801), $7.00

Vivian Shapiro, Edna Adelson, and Betty Tableman have edited a special issue of the Infant Mental Health Journal entitled *The Introduction of Infant Mental Health Services in Michigan*. The volume describes the collaboration of the Department of Mental Health, the University of Michigan and the state's community mental health system in providing the framework for the development of mental health services to infants and toddlers and their families in Michigan.

Individual articles deal with training of infant specialists; delivery of screening and intervention services in a variety of settings; outreach to high risk or disorganized families; and consultation to the courts in infant/toddler custody cases.

Human Services Insider (The Human Services Center [HSIC], 1408 N. Fillmore St., Suite 7, Arlington, VA 22201), $95/year.

Jule M. Sugarman and James I. Masters are co-editors of this new bi-weekly newsletter. Covering education, health, social services, community development and housing, rehabilitation, and income maintenance, the *Insider* reports on executive and Congressional proposals, new regulations, grant funds, activities of various human services coalitions, and state and local activities.

Conference Call:

March, 1982

March 27-28: *The Cleveland Association for the Education of Young Children and the Psychology Department, Case Western Reserve University* will sponsor a weekend institute on "The Care and Nurturing of Infants and Toddlers—A Professional Perspective." T. Berry Brazelton will deliver a keynote address and talk with parents. Write or call Jane Glander, 34420 McAfee Drive, Solon, OH 44139, tel: (216) 248-4756 (eves).

March 31-April 2: *The American Society of Law and Medicine* will sponsor a conference on "Legal and Ethical Aspects of Health Care for Children" in Los Angeles, California. Issues in the treatment of newborns with birth defects will be discussed. Write or call The American Society of

Law and Medicine, 765 Commonwealth Avenue, 16th Floor, Boston, MA 02215, tel: (617) 262-4990.

April, 1982

April 16-17: *The University of Maryland School of Medicine's Department of Psychiatry* and the *Maryland Institute for Child Study* will sponsor a conference on "The Infant and the Young Child: Developmental and Psychopathological Issues" in Columbia, Maryland. Faculty will include E. James Anthony, T. Berry Brazelton, Erik and Joan Erikson, Erna Furman, Stanley Greenspan, Reginald Lourie, Taghi Modarresi, and Anna Marie Weil. Write or call the Program of Continuing Education, University of Maryland School of Medicine, 10 South Pine Street, Baltimore, MD 21201, tel: (301) 528-3956.

April 27-29: *USEP (United Services for Effective Parenting) - OHIO* will sponsor a conference for those interested in replicating USEP's birth-to-three network model (described in **Zero to Three**, September, 1981) in their own states. For information, write or call Earladeen Badger at the Department of Pediatrics, U.C. College of Medicine, 231 Bethesda Avenue, Cincinnati, OH 45267, tel: (513) 872-5341.

April 28-30: The *E. John Gavras Center*, an affiliate of the United Cerebal Palsy Association, will hold a statewide conference on infant programs for the disabled in Auburn, New York. Among the speakers will be Marshall

Continued on following page

CLINICAL INFANT REPORTS

The first volume of the National Center's new series is Stanley Greenspan's **Psychopathology and Adaptation in Infancy and Early Childhood: Principles of Diagnosis and Preventive Intervention.**

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Klaus, who will speak on "Parent-Infant Bonding: Counseling Parents of a Malformed Infant." Write or call Stan Finkle, Infant Program Coordinator, E. John Gavras Center, 182 North Street, Auburn, NY 13021, tel: (315) 252-8282.

May, 1982

May 3-7: T. Berry Brazelton, Eli Newberger, and Michael Yogman will direct a course on "Early Intervention with Newborns and Older Infants" sponsored by the *Division of Child Development, Children's Hospital,* Boston, Massachusetts. Some twenty faculty members will meet with participants at the Holiday Inn in Dedham, Massachusetts. For further information, write or call the Harvard University Medical Center Department of Continuing Education, Boston, MA 02115, tel: (617) 732-1525.

May 8: *The Thirteenth Annual Margaret S. Mahler Symposium* is entitled "The Interrelationship of the Development of the Sense of Self and Mahler's Theory of Symbosis." Louis Sander, Daniel Stern, Margaret Mahler, John McDevitt, Anni Bergman and Judith Smith will be presenters at the Philadelphia meeting. Write or call Selma Kramer, M.D., Department of Psychiatry, Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia, PA 19129, tel: (215) 842-4145.

May 27-30: *The Sixth National Conference on Perinatal Social Work* will take place in Houston, Texas, sponsored by the National Association of Perinatal Social Workers. The program will include seminars, workshops, and special presentations. Write or call Jo Miller, Social Service Department, Jefferson Davis Hospital, 1801 Allen Parkway, Houston, TX 77019, tel: (713) 751-8352.

June, 1982

June 7-8: *INTER-ACT: The National Committee for Very Young Children with Special Needs and their Families* will hold its Second Annual National Conference at Boston University, focusing on the needs and program involvement of parents of very young handicapped children. For further information, write to Geneva Woodruff, Project Optimus/Outreach, South Shore Mental Health Center, 77 Parkingway, Quincy, MA 02169.

June 17-19: *The Day Care Council of America* will hold its 14th annual meeting in Washington, D.C. A pre-conference workshop on family day care networks will take place on June 16. Write or call Donna Franzel, Day Care Council of America, Inc., 711 14th Street, N.W., Suite 507, Washington, D.C. 20005, tel: (202) 638-2316.

June 21-25: Alice Honig will be principal presenter at *Syracuse University's* 6th annual course in "Training Caregivers of Children Under Three." Write or call Dr. Honig at Syracuse University, 100 Walnut Place, Syracuse, NY 13210, tel: (315) 423-3023.

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MATERNAL AND CHILD HEALTH NURSING: A PERSPECTIVE ON SERVICE, RESEARCH, AND TRAINING

by Kathryn E. Barnard, R.N., Ph.D.

Nursing is a vital element in the array of human services needed by infants and their families. Nurses contribute to infant health and development both in clinical work and through scientific studies of early development.

In Neonatal Intensive Care Units the very survival of fragile infants depends on the nurse's close monitoring and sensitive care. In high-risk populations, the work of nurse midwives has been shown to improve significantly the outcome of pregnancies (Diers, 1982). Hospitalized children have benefited from the work of nursing pioneers like Florence Blake and Florence Erickson, who demonstrated the importance of developmental and psychological factors in children's recovery from acute and chronic illness.

Nursing Roles

Much nursing involves regulating the environment on behalf of the individual. A child feels secure about being in an oxygen tent because he knows someone will come when he calls, and the nurse has arranged for the parents to stay nearby. The mother of a newborn is successful in her early breastfeeding, since the nurse ensured early opportunities for her baby to suckle right after delivery when mother and infant were both in an aroused and engaging state.

Nursing often involves caring for people in transition. During periods of instability, the individual is more vulnerable to environmental changes. The young infant who must be hospitalized in the latter part of the first year of life is a good example. Attachment theory tells us that at this time the presence of the child's primary caregiver is important; the nurse observes the child's reaction to parental separation and modifies the environment to support the child, making special provisions for the parent to give care and comfort in the hospital, or — if that is not possible — giving the child a consistent nurse caregiver.

Pediatric nurse in a California neonatal hospital.
WOMEN'S ACTION ALLIANCE

Recent studies we have done on nursing care for high-risk infants and their families during the first three months of life indicate that 50 to 75 percent of the nurse's activity with the family involves monitoring and surveillance (Newborn Nursing Models, 1982). In hospitals, especially in critical care settings, the nurse's constant surveillance of the patient's condition is

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National Center for Clinical Infant Programs 733 15th St., N.W., Suite 912, Washington, D.C. 20005 (202) 347-0308

obvious. The public health nurse in the community is also in a vital position both to monitor the health of the community and to direct families to needed resources. Especially for low-income families, the nurse is often the only link between need and help.

For families with young children, the nurse plays the important role of health teacher. Many families neither know how to care for children nor have links to family members who could pass on their own wisdom. What to do when the baby has a fever, how to prevent diaper rash, how to soothe an irritable baby, how to sense the baby's hunger and satiation cues are all important questions the nurse helps the new mother confront on a day-to-day basis. Prenatal and parenting classes are rapidly becoming popular. Nurses teach a majority of these classes, which strive to give families knowledge they will need in the childbearing and childrearing challenges to come, and to encourage self-esteem and positive feelings about parenting. As recently as 20 years ago, such classes were popular only with mothers; now, fathers are becoming more involved, allowing the instructor to support communication between parents and broadening new parents' base of support by putting them in touch with other couples.

In our recent study on nursing care for high-risk infants and families (Newborn Nursing Models, 1982), we developed an informational model to test whether parent-infant adaptation would be facilitated by providing information about infants to their parents. An instructional program called Nursing Support for Infant Bio-Behavior (NSIBB) was designed to facilitate the mutual adaptation process between caregiver and infant. Although the goals remained the same for each family, specific details were individualized to fit the personality and style of each mother and infant. We based the NSIBB program's content and activities on the known bio-behavioral changes that occur in all infants during the first three months of life, and we correlated these bio-behavioral changes with the schedule of nursing visits:

- **Week 1:** The primary task of the parents during this period is to acquaint themselves with their baby and to understand their baby's unique characteristics. They begin to identify who their baby is and develop ways of meeting the baby's needs. At this time the parents may express frustration about their infant's sleep-wake schedule, which will gradually increase in predictability.
- **Week 3:** During this period babies may be quite fussy, since the infant's peak amount of crying begins at approximately two weeks. These crying periods are extremely frustrating and overwhelming for parents. Crying may interfere with pleasurable periods between parent and infant and may hinder any kind of positive communication they may have established.
- **Week 5:** This is a transition time for parents and infants. Parents are often more at ease with their role and feel more confident in caring for the baby. The infant's feeding and sleeping patterns may be predictable. The parents begin to observe the infant smiing and establishing eye contact. On the other hand, the infant may still be fussy and his or her parents may be losing their patience with the baby.
- **Week 8:** During this period infants consolidate their behaviors and give clearer cues. Parents observe sociable behaviors in their babies such as smiling, visual tracking, ceasing to cry when they have been picked up, and differentiating the parents from other people. These behaviors make the parents feel that the infant recognizes them as specific individuals.
- **Week 12:** By this time many parents have established routines in caring for their baby. The parents and infant usually have learned to read each other's cues and to respond appropriately. When the parent and infant are together they exhibit a "give and take" rhythm. This rhythm is usually evident in most interaction periods.

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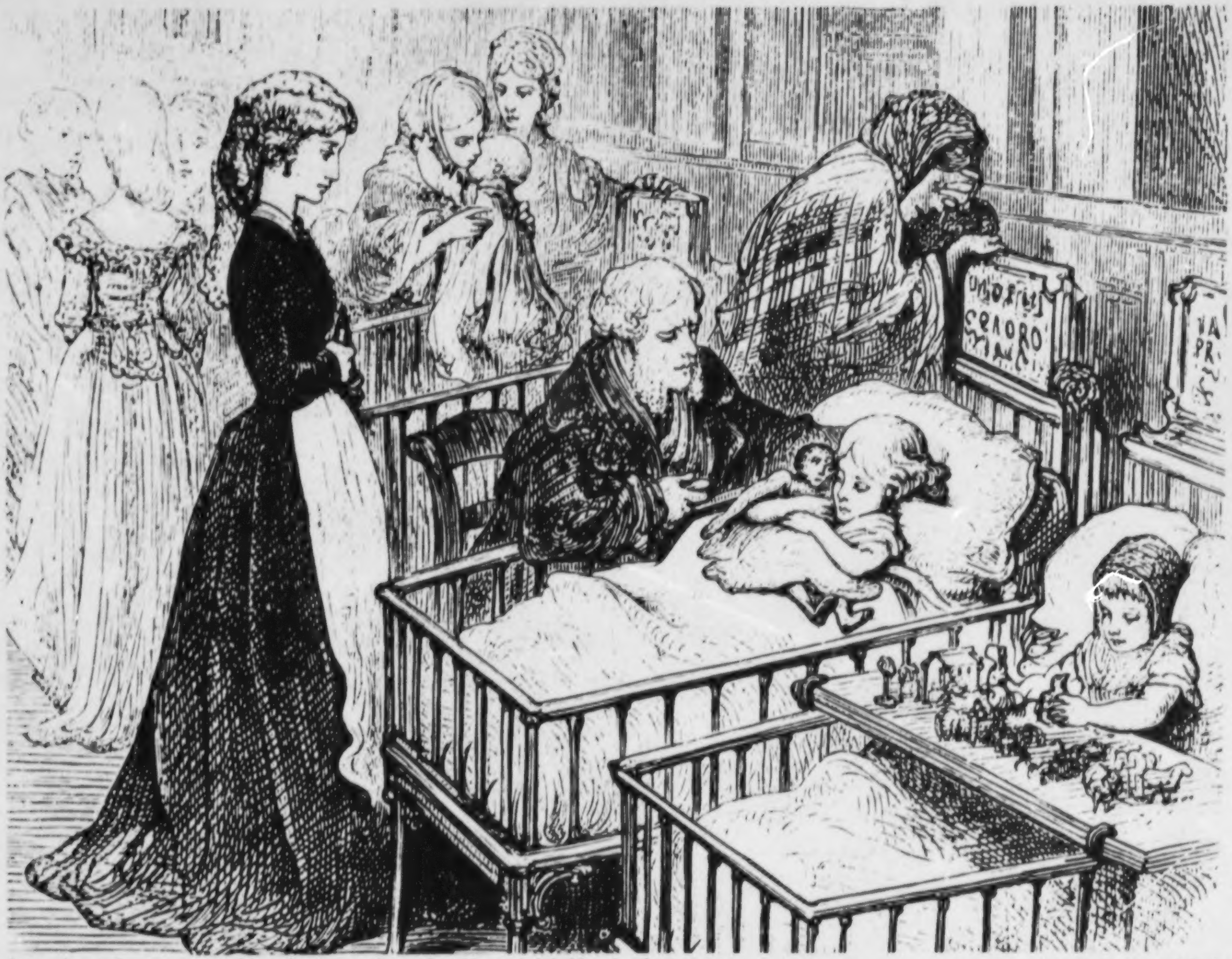

Infant hospital patients visited by relations, as depicted in Harper's Weekly, April 26, 1873. NATIONAL LIBRARY OF MEDICINE

Sharing information about infant communication with new parents can be a useful intervention strategy. Feeding problems such as failure-to-thrive can be alleviated by the parents' learning to watch for hunger and satiation cues from their infant.

The following material comes from the nurse's record of a **Week 2** home visit to an NSIBB family. The visit was with the 21-year-old primiparous mother and the infant's father. The infant had weighed 5 pounds, 14 ounces when it was born at 38 weeks gestational age.

. . . we sat down at the table and I asked her how things had been going . . . she told me how the baby had been having trouble gaining weight and had lost 9 ounces during the last two weeks (now 5 pounds, 5 ounces) . . . we started talking about the cues one sends to another person which indicate a desire to communicate. Prior to this point in the visit, the baby was fussing and crying but the mother stated that the baby wasn't hungry because the baby had eaten "within the last hour and a half." I suggested that "she watch the way the baby was turning as if to suck something and to listen to the smacking noises she was making." I pointed out some of those cues which said the baby was hungry. So the mother proceeded to feed the baby, but after giving her one ounce concluded that the baby was full. I pointed out the infant's smacking noises and urged her to feed the infant a little more. We then discussed the communication sequence and referred back to the particular cues we had seen in her infant . . . the pictures from Johnson and Johnson were used . . . the infant's father came over to look at these also. Both parents noted different pictures which seemed familiar — they had seen other infants or their own infant display the illustrated behaviors.

By the next visit, two weeks later, the infant was gaining and the nurse's record reported the following:

. . . in talking about the cues for feeding she reports that these have gotten easier for her to pick up on. Previously it had been very difficult for her to tell when the baby was hungry or wanting something. She said now there are certain things the baby will do such as mouthing and sucking on her hand, so she feels more confident about her ability to assess what the baby needs . . .

This case illustration reinforces the importance of knowledge of infant behavior and development as a foundation for parenting. Health care professionals and parents alike benefit from our increasing knowledge about infants' behavioral responsiveness.

Providing comfort and therapy in the presence of illness or disability is another role of the nurse. This is a nurturing role, oriented toward fostering the personal development of the individual, ill or well. In the Newborn Nursing Models study we found that as many as 20 percent of all nursing acts were of this supportive nature. When mothers lacked supportive partners or networks, nurses spent much time establishing a trusting relationship. Our clinical work with high-risk families has convinced use of the importance of Reva Rubin's (1961) theory that the capacity of the mother to invest in her child is directly proportional to how much others have invested in her. We have found that with the most problematic families — those who were in constant crisis — the best nursing approach was one based on assessment of the **mother's** needs, in contrast to the informational model discussed above. The nurses following this individualized model used interviews, questionnaires, and observations to identify the mother's patterns of behavior and her resources. In many cases, nurses found themselves focusing on the mother's relationship with her partner before it was possible to explore mother-infant interaction.

Training for Maternal and Child Nursing

Contrary to the pattern of nursing education in other countries, entry level preparation of the nurse in the United States produces a practitioner who is a generalist. Only through professional continuing education or graduate education does the nurse become prepared to practice specialized nursing with infants and children, and with parents during childbearing and childrearing.

The University of Washington has a six-quarter master's level graduate program to prepare the clinical nurse specialist in parent-child nursing. The first three quarters of study focus on the core of knowledge and practice within parent-child nursing; during the remaining three quarters the students specialize in nursing care of children, as either pediatric nurse practioners or perinatal nurses. Formal academic classwork is combined with supervised clinical practice.

Most universities with nursing programs offer master's preparation; about 25 offer preparation in the area of maternal-child or parent-child nursing. Information about the programs may be obtained from the National League for Nursing or from Peterson's *Annual Guides to Graduate Study: Biological, Agricultural, and Health Sciences,* 1982.

Doctoral study in nursing is also available at most major universities. At the University of Washington a Ph.D. in Nursing Science program emphasizes preparation for nursing research in five fields of study. Approximately one-fourth of the enrolled doctoral students are investigating problems related to parents and infants.

A training program called NCAST (Nursing Child Assessment Satellite Training) at the University of Washington is an example of short-term continuing education for nurses in this field. Twice a year, in June and December, we train individuals to teach others the use of two scales we developed for observing and assessing reciprocal parent-child interaction in feeding and teaching situations. Participants also learn to use the Caldwell Home Inventory (1978), an adapted version of the Brazelton Neonatal Behavioral Assessment Scale, and a sleep-activity record. More than 130 people from all parts of the country have taken this training course and have, in their turn, taught the assessment methods to some 2,500 professionals in their own communities.

Nursing Research

A growing number of nursing periodicals reports developments in the rapidly expanding field of nursing research. Journals include:

Advances in Nursing Science, American Journal of Nursing, American Journal of Maternal-Child Nursing, Journal of Advanced Nursing, Journal of Obstetrical, Gynecological and Neonatal Nursing, Maternal-Child Nursing Journal, Nurse Practitioner, Nursing Research, Pediatric Nursing, Research in Nursing and Health, and the Western Journal of Nursing Research.

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TRAINING THE PEDIATRICIAN IN THE PSYCHOSOCIAL ASPECTS OF CHILD HEALTH

by Morris Green, M.D.
Lesh Professor and Chairman
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While sharing much in their concern for children, the pediatrician and the child pscyhiatrist differ from one another in several aspects of the content, competencies, and style of their role and practice. These aspects include the length, frequency and number of visits; therapeutic techniques used; types of clinical problems confronted; theoretical background; primary or secondary nature of the contact; availability; and competence in dealing with unconsciously motivated and irrational behavior.

In 1948, Milton Senn, a pioneer in the introduction of psychodynamic concepts into pediatric practice, envisioned that pediatricians would develop a balanced competency in both the psychosocial and the biomedical aspects of child health.[1,2] Thirty years laters, the Task Force on Pediatric Education reported that more than half of general pediatricians surveyed regarded their residencies as inadequate in training and experience in the developmental and behavioral aspects of pediatrics.[3] While Senn's vision has not yet become a reality, the improvement of training in the psychosocial aspects of child health is a prominent item on today's agenda for pediatric education.

Factors contributing to a new trend

Several circumstances account for this metamorphosis. First, the dramatic improvement in the health status of children has permitted an extension of interest beyond biomedical disease to include psychosocial and developmental pediatric issues. Second, the growth in manpower and the group practice of pediatrics have allowed generalist pediatricians to pursue special interests in developmental and behavioral aspects of the field. The American Board of Pediatrics' recent requirement that candidates for certification have three, rather than two, years of general pediatric training before fellowship training is a third factor contributing to the broadening of pediatric education. Accreditation of residency programs by the Residency Review Committee for Pediatrics also requires that the behavioral and developmental aspects of pediatrics be adequately addressed and continuity of care to a panel of patients be provided.

Resident readiness, faculty effectiveness

A pluralism of needs and interests influences the individual and professional readiness of residents for training about the psychosocial aspects of pediatrics. Personalities, experiences, individual capacities, and educational expectations are all involved. Some new residents come to pediatrics primarily out of an interest in the diseases of children, especially those disorders seen in hospitals; others bring a more comprehensive view. But whether or not residents initially have an awareness of or an interest in the psychosocial and developmental aspects of pediatrics, most are receptive to learning opportunities. Their openness is, of course, greatly fostered by admired teachers, by the support of the chairman and other faculty for these aspects of pediatric education, and by the resident's belief that such training is relevant for practice.

> **"Pediatric training, like all educational ventures, to be truly effective must provide ample opportunity for the establishment of intimate teacher and pupil relationships. With these at the core of training, not only will pediatricians learn the fundamentals of child care but they will be able to incorporate quite naturally psychologic insight with medical understanding and so make pediatrics the comprehensive discipline it must be."**
>
> **—Milton Senn**

Fortunately, the number of faculty members in child development and psychosocial pediatrics has been increasing steadily, facilitated by federal and private training grants, including eleven awards by the William T. Grant Foundation to departments of pediatrics for residency training in behavioral/developmental pediatrics. Ideally, directors of such programs should be pediatricians who themselves have had fellowships in child development/psychosocial pediatrics or training in child psychiatry. Discussions about disease and disease processes rank high in the interest of pediatric residents, who may be more apt to learn from teachers (admittedly few in number) whom they consider well-informed in those areas as well as competent in the psychosocial and developmental spheres.

Faculty interested in the psychosocial aspects of pediatrics are most effective when they are regularly visible on the patient care units, easily accessible, readily available to assist house officers in both ordinary and difficult diagnostic and management situations, and able to demonstrate on site how information about human behavior, social influence and economic forces can be decisively helpful in the care of a specific child or family.

Educational goals

In three years of training, the resident should:

- develop a scientific curiosity about human behavior;
- acquire skill in interviewing as the basic tool for pediatric diagnosis and as a way to help patients psychologically;

A Board of Health doctor in a New York tenement. From Harper's Weekly, August 10, 1889.

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- perform a physical examination that includes physical and mental status findings, provides reassurance for the family and promotes a constructive physician-patient relationship;
- deal at some level with simultaneous diagnosis and treatment in both the biomedical and psychosocial aspects of pediatrics;
- be aware of feelings within himself or herself and his or her patients;
- give parents and child the feeling that they are understood;
- gain the patient's acceptance, when that is feasible, of the relevance of psychosocial factors to the complaint;
- help the child form a realistic assessment of his capabilities;
- deal with feelings of anxiety, anger and depression;
- counsel and clarify;
- support the child's healthy adjustment to situations that realistically will not change;
- have the child like and trust him or her;
- be comfortable and friendly, and relate in a strongly positive fashion;
- identify with the physician's constructive attitude toward the child's health; and
- gain the patient's compliance with the therapeutic plan.

Given the constraints of time, funding and service needs, these ambitious goals are not easily achieved.

Integration, collaboration, supervision

While the specific curriculum implemented by an individual training program will depend upon its unique strengths and resources, the knowledge, skills and attitudes relevant to the psychosocial aspects of pediatric education are best integrated around patients in the resident's **day-to-day** experience. This integration needs to happen in primary, secondary and tertiary care training and experience. It must take place in the prenatal clinic, the newborn nursery, the neonatal and pediatric intensive care centers, other inpatient units, the emergency room, the ambulatory service (with its continuity, specialty, consultation and walk-in clinics) and practitioners' offices. Otherwise, psychosocial and developmental considerations may be regarded as special or different rather than regular and pervasive.

Collaboration with child psychiatrists, psychologists, pediatric nurses, social workers and child life workers on the regular hospital staff in the assessment and management of patients helps define for the resident what he or she can best do independently and when joint management, consultation or referral are indicated in the best interests of the child. Schools, child guidance clinics, adoption agencies, courts, detention centers and day care centers offer other opportunities to gain consultation skills in relation both to individual children and to agency policies, priorities and standards.

The resident should have **supervised** experience in:

- the continuing care of well children (including those living in one-parent, adoptive or foster homes or with working mothers);

- the management of family crises such as separation, divorce, death, suicide, accidents, child abuse and neglect and sexual assault; and
- those disorders for which pediatric diagnostic and **management** skills are appropriate and those for which diagnostic and **referral** skills are needed. The former includes failure to thrive, rumination, developmental delay, breath-holding spells, feeding problems, temper tantrums, pica, sleep disorders, separation difficulties, tics, school avoidance, school underachievement, anorexia nervosa, enuresis, psychogenic somatic complaints (recurrent abdominal pain, chronic fatigue, headaches, chest pain and vomiting) and the psychologic aspects of long-term illness and handicap; examples of the latter are infantile autism, failure of maternal attachment, delinquency, gender identity disorders, chronic depression, child custody and parental emotional illness.

The behavioral and social sciences and the field of child development have enriched pediatric education with an infusion of relevant literature, skills and attitudes. These disciplines have much to offer pediatricians dealing with normal physical and psychosocial growth and development; the reactions of children to illness and death; the complexities of parent-child relationships and family dynamics; issues of patient compliance; and the signficance of psychologic tests to assess status, aptitude, and achievement.

Opportunities for continuing education

Beyond the residency, the practitioner who wishes to enlarge his understanding of the psychosocial aspects of pediatrics may choose from a range of continuing medical education activities, including seminars, lectures, grand rounds, courses in pediatric interviewing, mini-residencies, fellowships and self-study. Study groups, which meet weekly under the direction of a qualified pediatrician or child psychiatrist to discuss patients being seen by one of the participants because of a behavioral or developmental problem, are highly effective. The practitioner may also schedule consultation sessions from time to time with a child psychiatrist to discuss selected patients.

Textbooks and journals which emphasize the developmental and behavioral aspects of pediatrics are becoming increasingly available. For a list of suggested readings, write to **Zero to Three.**

Progress in the profession

The Study Group on Pediatric Education, the successor to the Task Force on Pediatric Education, with representatives from the major pediatric societies, recently completed the preparation of two position papers: **Pediatric Graduate Medical Education: The Psychosocial Aspects of Child and Adolescent Health** and **Pediatric Graduate Medical Education: Disorders of Learning.** Draft copies of these reports are now being reviewed by the constitutent societies. Papers will be available from the author on completion of this review.

The Executive Board of the American Academy of Pediatrics has recently appointed a Committee on the Psychosocial Aspects of Child and Family Health, charged with the integration of psychosocial considerations into the practice of pediatrics. This committee chose health supervision as the initial area for action since pediatricians spend over fifty percent of their time in well-child care; health supervision visits offer regular opportunities for prevention and early intervention; information from child development and developmental psychology should be incorporated into clinical practice; and parents need to be better informed about the importance of regular health supervision visits.

The committee plans to develop packages of materials describing well-child care from the prenatal period through adolescence. These summaries, which will include both biomedical and psychosocial content, augmented by footnotes and addenda, are to be prepared initially for the prenatal, newborn, first, second, fourth, sixth, ninth, and twelfth month visits and, later, for the remainder of health promotion visits through adolescence. More information about the work of the Committee is available from Nancy Witte, American Academy of Pediatrics, P. O. Box 1034, 1801 Hinman Avenue, Evanston IL 60204.

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TRAINING IN CLINICAL CHILD PSYCHOLOGY

The Journal of Clinical Child Psychology's Spring 1982 issue (Volume 11, Number 1) focuses on training in the field of clinical child psychology. Six articles review current programs of graduate training, discuss alternative models of training, and survey practicing clinical child psychologists about their work and the adequacy of their training. This issue also presents a proposal for a national conference on professional preparation of clinical child psychologists.

For a copy of the **Journal**, write to the Business Office, Journal of Clinical Child Psychology, Child Study Center, 1100 N.E. 13th, Oklahoma City, Oklahoma 73117.

NATIONAL CENTER FELLOWSHIPS: 1981 & 1982

Training professionals in the fine art of identification, remediation and prevention of developmental problems at birth is a primary goal of the National Center for Clinical Infant Programs. The National Center seeks to meet this goal in part with a Fellowship Program which offers skills enrichment to professionals already involved with infants, young children and their families.

In 1981, eleven doctoral and post-doctoral practitioners were selected for a two-year Fellowship. They attended the National Center's Training Institute in December and the May Scientific Meeting of scholars from the field. They presented papers on their independent work during a week-long seminar at the Yale Child Study Center and, at the same time, reviewed the facilities and special programs in infant development at the Yale Center with its leaders.

Some highlights of growth and accomplishment occurred among the Fellows in research and clinical practice who are graduating from the program this spring to go on to full-time teaching and practice in the field:

- **Peter Dawson**, a pediatrician at the University of Colorado Health Sciences Center, continued research in family support and offered consultation to staffs at developmental clinics, to students in clinical child psychology, and to trainees of the Medical Center;

- **Bruce Miller, M.D.**, a specialist in infant development at the University of Colorado Health Sciences Center, has been able to go on in his research and join a project with the Developmental Psychobiology Research Group of the Center;

- **Patricia Nachman,** a developmental psychobiologist from New York Hospital-Cornell Medical Center, completed a project on infant memory and has begun another on infant depression;

- **Jack P. Shonkoff,** a pediatrician, Child Development Center, University of Massachusetts, is working on a series of clinically-based studies on the variable patterns of early childhood development; and

- **Fred C. Volkmar,** a child psychiatrist at the Yale Child Study Center, has continued research with severely impaired chldren while broadening his background in clinical work with infants and their families.

- Other Fellows are involved in studies of autistic children, socially vulnerable chldren, teenage mothers with high-risk infants, and individualized efforts to overcome health and physcial handicaps.

Of the 1981 Fellowship group, six will continue into their second year of study under partial National Center auspices:

Barbara Kalmanson, special educator, University of California, San Francisco;
Rebecca Ruth Kang, nurse, University of Washington, Seattle;
Dorothy Ann Kirkpatrick, nurse, Erikson Institute, Chicago;
Sherri MacKay-Soroka, developmental psychologist, University of Toronto;
Mili Mass, social worker, University of California, San Francisco;
Charles Henry Zeanah, Jr., M.D., child psychiatrist, Stanford University.

Ten new Fellows were appointed in early May for the 1982-83 Program. The group of three men and seven women includes a doctor of mental health, an early childhood education specialist, a nurse, two developmental psychologists, and five pediatricians. They come from Canada and the eastern midwest, southern and western U.S. and range in age from 26-36. Each has a strong academic and professional background; several have multiple degrees and have published studies in the field. Everyone has a strong commitment to the importance of increased personal understanding and a dedication to greater profession-wide recognition of the importance of cognitive, emotional and social development in very young children.

It is with great pleasure that the National Center announces the National Center Fellowship awards for 1982:

- **Kathleen Ann Fearn, M.D.,** pediatrician, child development, Yale Child Study Center;
- **Susan E. Gottlieb, M.D.,** pediatrician, child development, Harvard-Children's Hospital Medical Center;
- **Nancy Ruth Kaplan,** developmental psychologist, University of California-Berkeley;
- **Daniel B. Kessler, M.D.,** pediatrician, Children's Hospital Medical Center, Boston;
- **Mark Allen Sands, M.D.,** child psychiatry resident, Baylor College of Medicine, Houston;
- **Stephen Philip Seligman,** doctor of mental health, University of California-Berkely;
- **Robin Barnes Thomas,** nurse, University of Washington, Seattle;
- **Leigh Alynne Thorpe,** doctoral candidate, developmental psychology, University of Toronto;
- **Clyniece Lois Watson, M.D.,** pediatrician in public health, Erikson Institute, Chicago;
- **Donna Sasse Wittmer,** doctoral candidate, child development, Syracuse University.

ANN LANDERS WRITES ABOUT INFANTS, PARENTS, AND PROFESSIONALS

For more than 26 years, Eppie Lederer, better known as Ann Landers, has provided a unique blend of assessment, information and referral, and developmental guidance and family life education to some 70 million clients in a catchment area extending from Maine to Bangkok. She accomplishes this through her daily newspaper column, which is carried in more than 1,000 publications served by Field Newspaper Syndicate. Ann Landers regularly consults with experts in psychiatry, psychology, medicine, dentistry, law, sociology, religion, education and economics, as she frames responses to those seeking her counsel.

After reading two recent letters (reproduced below) which addressed problems of parents and their very young children, we decided to write our own letter to Ann Landers — the third printed below.

Dear Ann Landers:

As I write this, my little boy is lying on the couch under an ice bag. His face is as red as a beet, and the skin is broken in a few places where I slapped him. When he gets stubborn or has a tantrum, I become so angry I can't control myself. I have hit him like this several times before, even though I know it is wrong.

I read your column every day and have read your advice to look in the phone book under child abuse. I looked and there is nothing in this town (population 3,000).

When this boy was born four years ago, I really didn't want him, but my husband was crazy about children and insisted that I have a family. I have always hated this kid, which is a terrible thing for a mother to admit, but it is true. His daddy died two years ago and, thank God, I don't have any others. I am a rotten mother.

Many times I have thought of giving up the boy for adoption. I know there are many couples who would love to have him. He is very smart for his age and darling looking. But just when I get ready to put my hand on the phone, I tell myself, "Don't do it. Keep him and learn to be a good mother."

I live 1,500 miles away from my own family. I have a good job and work 50 hours a week. Please tell me what to do.

— Telling It Like It Is in Kansas

Dear Telling It:

My heart aches for that little boy on the couch. And for you, too. I know the guilt must be killing you. You must get help at once. Call Parents Anonymous immediately. They may be able to give you a local number to contact in your area. The toll-free number, in every state except California, is 800-421-0353. Another alternative: Write to the National Center on Child Abuse and Neglect, P.O. Box 1182, Washington, D.C. 20013, for information and help. I see by your envelope that you are not too far from Topeka, Kansas. If there is no Parents Anonymous group in Manhattan, Kansas, try Topeka and Kansas City. Good luck.

Dear Ann Landers:

I promised my husband I would return to work when our daughter was 6 months old. I figured by then I would be ready to take her off the breast and put her on the bottle. Well, she will be 6 months old in two weeks and I am NOT READY.

I have this tremendous feeling of guilt because I am not contributing financially. It is very difficult to make ends meet with one paycheck. We do manage if I cut corners, and I'm trying, but my husband has told me I must keep my word and go back to work.

How can I convince him that I need to stay home at least another month or two? Emotionally I am so torn. Please help.

— Too Much a Mama?

Dear Mama:

The bonding that occurs in the first year of life between a mother and child can be crucial. I urge you to hold firm against your husband's insistence. Tell him there is no going back and reliving that first year of your child's life. The few extra dollars you will earn cannot compensate for the problems that might result.

Dear Ann Landers:

We are doctors, nurses, social workers, psychologists, teachers and day care providers working with infants and their families. During the last 15 years researchers and clinicians among us have learned new ways to diagnose developmental problems in infants in the earliest months of life and to work with parents to address problems quickly in order to insure the healthiest possible development of all infants.

You receive letters from countless parents looking for help. What are the unmet needs you hear about most often? What suggestions can you give us professionals for letting people know the importance of early diagnosis and intervention in helping infants? Do the letters you receive suggest ways in which we can be more sensitive to parents' concerns and effective in working with families?

Sincerely,
Sally Provence, M.D.

Dear Sally:

I do, indeed, hear from parents who are frustrated, angry, remorseful and loaded with guilt because they feel inadequate — unable to relate in a loving way to their children.

There are no easy answers or simple solutions to these problems. The best approach is education. These parents need to know that they are not alone — that their problem is shared by millions of others and that they should not be ashamed to seek professional help or join such organizations as CALM and Parents Anonymous.

I do what I can to pass the word. Happily I have 70 million daily readers and I know I am getting through to some of them because they write and tell me. I can only say to the professionals in the field, just keep on doing what you're doing. You will fail in some instances, but you will surely succeed in others. Remember that many of the parents who come to you need continuing help — the emotional support of counseling and the comfort that comes from meeting others who share their problem.

Hang in there, and so will I. Eventually, we're bound to make a dent.

Sincerely,
Ann Landers

For Your Information:

The Ounce of Prevention Fund represents a new partnership between the Illinois Department of Family Services (DCFS) and the Pittway Corporation Charitable Foundation. Each organization is supplying $400,000 to provide funds for primary prevention projects in Illinois.

Taking its name from the adage that an ounce of prevention is worth a pound of cure, the fund is based on the belief that when children fail, the tragedy and the cost are borne by parents, children, and the society at large. The fund's leaders hypothesize that expenditures for family support programs which improve parents' self-esteem and competence will reduce costs otherwise paid for remedial help.

In the Ounce of Prevention approach,

- all demonstration programs will be community based;
- all projects will be primary prevention programs;
- all programs will have rigorous data collection components so that program results can be evaluated by an independent research team measuring the cost-effectiveness of primary prevention with parents and infants.

The Fund is now in the process of selecting four project sites from the 115 applicants who submitted proposals, choosing an evaluation contractor, and establishing a professional advisory committee of nationally recognized experts. For further information, contact Irving Harris, Chairman of the Board, Pittway Corporation, 120 South LaSalle St., Suite 1320, Chicago, IL 60603, tel: (312) 621-0650 or Gregory L. Coler, Director, Illinois Department of Children and Family Services, 1 North Old State Capital Plaza, Springfield, IL 62706, tel: (217) 785-2509.

The Office of Human Development Services (OHDS) expects to award approximately $2 million in FY 1982 for new research and demonstration grants under the Child Abuse Prevention and Treatment Act of 1974. Projects may be designed to increase knowledge in specific areas of the field, demonstrate comprehensive prevention service strategies, or further protection of children in out-of-home placements.

The closing date for receipt of applications is July 19, 1982.

For application kits and further information contact the National Center on Child Abuse and Neglect, Attn: Grants Administration Specialist, Children's Bureau/ ACYF, P.O. Box 1182, Washington, D.C. 20013, tel: (202) 245-2840.

Following a Special Research Grant Announcement for research proposals on mental health clinical services for infants and their families, the National Institute of Mental Health awarded a total of $500,000 in "new start money" to three multi-year research efforts and one pilot project beginning in April, 1982.

Grantees are: **Kathryn E. Barnard, R.N., Ph.D.** (School of Nursing, University of Washington, Seattle); **Joy D. Osofsky, Ph.D.** (Menninger Foundation, Topeka, Kansas); **Arthur H. Parmelee, M.D.,** (Department of Pediatrics, University of California at Los Angeles); and **Bennett L. Leventhal, M.D.,**(Department of Psychiatry, University of Chicago)

For further information about NIMH funding for prevention and early intervention research proposals, contact Vicki Levin, 2340 University Blvd. East, Adelphi, MD 20783, tel: (301) 436-7308.

Publications of the Office of Human Development Services (OHDS) which used to be distributed to the public without charge will soon carry a price tag, according to an order signed by HHS Secretary Richard Schweiker on April 16. For the time being the policy will apply *only* to OHDS, which is a relatively small agency by HHS standards but which publishes such Government Printing Office best sellers as **Infant Care** and **Your Child from One to Six.** Depending on results, the policy may be extended to all branches of HHS.

Until new procedures go into effect this summer, non-profit service agencies, preferably those with a walk-in clientele, can take advantage of a one-time HDS warehouse-cleaning and order up to 50 copies each of HDS publications for distribution to clients.

(Individuals may also continue to request free single copies of publications for the time being.) **Zero to Three** readers may find the following titles particularly useful.:

Infant Care (OHDS 80-30015), **Your Child From One to Six** (OHDS 79-30026), **A Parent's Guide to Day Care** (OHDS 80-30270), **So You're Going to Be a New Father** (OHDS 78-30028; Spanish version — OHDS 74-63), **Toys: Fun in the Marking** (OHDS 79-30031; Spanish version OHDS 74-30062), **Young Children and Accidents in the Home,** (OHDS 79-30034; Spanish version OHDS 79-30061)

To request publications or to obtain further information, contact Pat McKelvey, Director of Public Affairs, OHDC, 200 Independence Avenue, S.W., Room 329D, Washington, D.C. 20201, tel: (202) 472-7257.

Funding also ceased, as of March 31, 1982, for Closer Look, an information and resource project of the Parents Campaign for Handicapped Children which had been under contract to the Department of Education. **Closer Look** had produced **One Step at a Time**, a handbook for parents of handicapped children reviewed in the March issue of **Zero to Three.**

The National Center has inherited a supply of **One Step at a Time.** Please write to us for copies, enclosing $1.00 per copy for postage and handling.

Head Start's 37 Parent and Child Centers (PCCs) will continue to be funded "for the foreseeable future" and will continue their focus on parents and children three years of age and under, according to Warren Master, Deputy Commissioner of the Administration for Children, Youth, and Families. Conversion of the PCCs to regular Head Start programs had been a policy option under consideration by the Office of Human Development Services, which administers Head Start.

HHS's ten regional offices will continue to be the funding source for the Parent Child Centers as well as the best source of information about these programs.

House Resolution 421, introduced by Representative George Miller of California on March 31, 1982 would establish a Select Committee on Children, Youth and Families in the 98th and 99th Congresses. According to Miller, the Committee would "rescue children from their current invisible status in the legislative process" and provide a continuing review of the status and needs of children and their families.

Representatives Gifford, Weiss, Hyde, Waxman, Rousselot and Boggs co-sponsored the resolution. More than 100 other members of Congress have endorsed the effort, as have more than 50 national organizations, including the National Center for Clinical Infant Programs.

To find out whether your Congressman has endorsed the Select Committee proposal, write or call Ann Rosewater, c/o Congressman George Miller, 3422 Rayburn Building, Washington, D.C. 20515, tel: (202) 225-2095.

Child Watch, a collaborative effort of the Children's Defense Fund and the Association of Junior Leagues, is monitoring the effects of federal budget cuts on children in some 45 communities across the country.

Using a standardized manual, volunteers will identify and interview local administrators, service providers, and advocates about child care, child health and welfare, and Aid to Families with Dependent Children over a nine-month period. Multiple records of interviews are designed to reveal changes in the status of services to children as the impact of budget cuts reaches communities. Child Watch materials also guide volunteers in setting up a public information component to make elected officials and the general public aware of survey findings.

For copies of the Child Watch Manual or further information, contact Helen Blank or Fran Eizenstat, Children's Defense Fund, 1520 New Hampshire Avenue, NW, Washington, D.C. 20036, tel: (800) 424-9602.

KIDSPAC is a political action committee formed in December, 1981 "to support members of Congress who seek constructive alternatives to address the problems of and opportunities for children and families." It is located at 80 Trowbridge St., Cambridge, MA 02138, tel: (617) 492-2229. KIDSPAC's treasurer is William W. Harris.

The Political Action Committee to Protect children and Youth is raising funds "to build a constituency of public officials . . . committed to the needs of young people" in Washington and within New York State. The Committee's headquarters are at 12 W. 37th Street, 8th Floor, New York, NY 10018, tel: (212) 736-7440.

A call for papers has been issued by the National Early Childhood Conference, which will meet in Washington D.C. December 13-16, 1982. Papers may be on any topic concerning young handicapped children and their families: reports of original research on the efficacy of intervention, theoretical models, and documented practices will be considered.

The deadline for abstracts is July 15, 1982. Abstracts must be no more than 600 words in length and should include information on population, methods, materials, analyses of results, and interpretation and implications. Submit abstracts to Warren Umansky, 570 Aderhold, University of Georgia, Athens, GA 30602.

Publications:

MONOGRAPHS AND PROCEEDINGS

Advances in Infancy Research; Monographs in Infancy — Lewis P. Lipsitt, editor (Ablex Publishing Corporation, 355 Chestnut Street, Norwood, NJ 07648).

These two series join the journal, **Infant Behavior and Development**, also edited by Lipsitt and published by Ablex, to form a tripartite publishing program on infancy. **Advances in Infancy Research** is designed as a forum for technical and scholarly manuscripts which are "critical syntheses of specialized research areas" in both human and animal infancy. The **Monographs** will report original data and describe extended research programs at greater length.

The first volume of **Advances in Infancy Research** ($30) includes contributions by Marc Bornstein, Jerome Bruner, Tiffany Field, Michael Lamb, Michael Lewis and Candice Feiring, Mechthild and Hanus Papousek and Carolyn Revee-Collier and Jeffrey Fagen. The initial volume in the **Monographs** series is Wanda Bronson's **Toddlers Behavior with Age-Mates: Issues of Interaction, Cognition, and Affect**, priced at $14.95.

Birth Defects: Original Article Series, Volume *XVII*, 1981 —published by Alan R. Liss, Inc., New York, for the March of Dimes Birth Defects Foundation.

Pregnancy and Childbearing During Adolescence: Research Priorities for the Future, edited by Elizabeth R. McAnarney and Gabriel Stickle, and **Perinatal Parental Behavior: Nursing Research and Implications for Newborn Health**, edited by Regina Placzek Lederman and Beverly S. Raff, are numbers 3 and 6, respectively, in the seventeenth volume of the Birth Defects Original Articles Series.

Pregnancy and Childbearing During Adolescence ($28) contains an overview of incidence, risks, and consequences of adolescent pregnancy and childbearing, as well as eleven specialized papers. Research priorities for the field are listed in each paper and in a final summary.

Perinatal Parent Behavior: Nursing Research and Implications for Newborn Health ($46) grew out of a 1980 research roundtable conducted by nurse researchers. Eleven papers explore factors influencing the health and well-being of the family during the perinatal period.

REPORTS

Child Health Policy in an Age of Fiscal Austerity: Critiques of the Select Panel Report — Ron Haskins, editor (Ablex Publishing Corporation, 355 Chestnut Street, Norwood, N.J. 07648) $22.50.

The papers in this volume examine a variety of policy issues raised by the December, 1980 report of the Select Panel for the Promotion of Child Health.

Lisbeth Bamberger Schorr, Chairperson of the Panel, summarizes the report and its recommended actions to expand prenatal and perinatal care, comprehensive health care for children from birth through age five, and family planning services. Additional chapters consider state-federal relations, regulatory issues, government and family responsibilities for child health, manpower needs in child health, alternative delivery systems, effects of budget cuts on childhood mortality and morbidity, and the challenge to health programs posed by the New Right.

The Promotion of Breast Feeding (Policy statement based on the American Academy of Pediatrics' Task Force on the Promotion of Breast Feeding: in **Pediatrics,** May, 1982 or available as a reprint from the AAP, P.O. Box 1034, 1801 Hinman Avenue, Evanston, IL 60204) 50 cents.

This report explores the factors surrounding maternal choice of how to feed an infant, discusses alternatives to breastfeeding from antiquity to the present, delineates ways in which professionals can encourage breast-feeding, and examines issues involved in the advertising of infant formula. Encouraging optimal infant nutrition through the promotion of breast feeding is deemed a "primary goal" of the American Academy of Pediatrics, and this report makes a number of recommendations to pediatricians and other health professionals for achieving this end.

BOOKS

Children with Handicaps: A Medical Review —Mark L. Babhaw and Yvonne M. Perret, illustrations by Elaine Kasmer (Paul H. Brookes Publishing Company, P. O. Box 10624, Baltimore, MD 21204, 1981) $18.95.

Children with Handicaps is designed as a basic text for professionals (without medical training) who work with developmentally disabled children and their families and for parents and prospective parents.

The book begins with an introduction to heredity and the diagnostic techniques used to detect abnormalities before birth. It discusses fetal and infant development and the special problems of premature and dysmature infants. A second section of the book examines various organ systems and describes various handicapping conditions in depth. The last portion of **Children with Handicaps** concentrates on the emotional aspects of living with a handicapped child and raises some of the ethical questions faced by professionals and parents in caring for such a child.

Case histories are used throughout the text. More than 100 illustrations are included, as are a nontechnical glossary of medical terms, reference lists for each chapter, and a list of resources for handicapped children.

PHOTO BY BARBARA YOUNG

Parent-Infant Bonding, Second Edition — Marshall H. Klaus and John H. Kennell (St. Louis, MO: The C.V. Mosby Company, 1982) $17.95 hard cover, $13.95 soft cover.

In this second edition of **Maternal-Infant Bonding,** Klaus, Kennell, and six other contributors have made extensive revisions of all chapters in an effort to make use of the "explosion of knowledge" about birth, interaction, and attachment that has taken place in the six years since the earlier volume appeared.

While continuing to emphasize the importance of close contact of mother and father with the newborn in the first minutes and hours of life, the authors stress that this interaction is only the beginning of a "complex human psychobiological process" which continues for many years. The authors have also added a new chapter on siblings and a section on alternative birth centers.

Comments from some nineteen outside authorities (including Kathryn Barnard, T. Berry Brazelton, and Albert Solnit) appear throughout the text.

Vulnerable but Invincible: A Study of Resilient Children — Emmy E. Werner and Ruth S. Smith (New York. McGraw-Hill Book Company, 1982) $18.95.

Beginning in the mid-1950's, psychologists Werner and Smith studied 698 multiracial children on the Hawaiian island of Kauai. **The Children of Kauai** and **Kauai's Children Come of Age** presented data on these children from the fourth week of gestation to adolescence.

Two hundred and four children in the cohort developed serious behavior or learning problems at some time during the first 20 years of their lives. Yet other children, also exposed to poverty, biological risks, family instability, and parents with little education or serious mental health problems, seemed to remain "invincible." In **Vulnerable but Invincible**, the authors attempt to provide a longitudinal perspective on children's capacity to cope with a variety of stresses; to examine sex differences in vulnerability and resiliency; and to identify protective factors within the child and the care-giving environment that differentiate high-risk children who are resilient from those who develop serious learning and behavior problems. The book includes both case studies and statistical findings.

The authors conclude: "The central component of effective coping with . . . inevitable life stresses appears to be a sense of coherence . . . a feeling of confidence that one's internal and external environment is predictable and that things will probably work out as well as can be reasonably expected. The real issue may well be whether the families and societies in which children grow up and live their daily lives facilitate or impede the development and maintenance of such a sense."

National Center Notes:

by Eleanor S. Szanton

In this issue of **Zero to Three** we focus on professional training, a key subject for the field of infant mental health and development. Kathryn Barnard offers a nursing perspective and Morris Green suggests ways of training pediatricians in a developmental approach to children. Amanda MacKenzie, Director of the National Center's Training Programs, reports on the success of one of our major training initiatives, the Fellowship program.

Some other notes of interest:

- The 11th edition of the Encyclopedia Brittanica, published in 1911 and considered for years a remarkable repository of collected wisdom, has the following to say, among other things, under the heading "Infants":

> "A newborn infant is deaf . . . on the 4th day there is some evidence of hearing, and at the 5th week noise in the room disturbs it.
>
> . . . At the 6th month it knows its parents, and should be able to hold its head up.
>
> . . . By the 14th month the intelligence should be developed and memory is observed." (Vol. XIV, p. 514)

That such naive observation of infant behavior continued until recently may seem less surprising when one reads elsewhere in the article that the infant mortality rate was 178 per 1,000 births in Paris at the turn of the century. With 1980 U.S. rates down to 12.5 per 1,000 (a 14-fold improvement), new parents—and professionals—can observe babies' early development with much greater assurance that their investment of care and concern will be rewarded by healthy growth.

- The Chairman of the Board of the National Center, Dr. Reginald Lourie, has recently received an award from the American Orthopsychiatric Association. It was given jointly to Dr. Lourie and his brother Norman, *each* of whom is a past President of "Ortho." The award, made during the Association's Conference on Families, honors the commitment of the Lourie family to the field of mental health.

We congratulate those pioneers, such as Dr. Lourie, who have helped us to observe infants with new attention, to understand their development from fresh perspectives, and to recognize, in Dr. Lourie's own words, that "yesterday's children are bringing up tomorrow's parents."

Conference Call:

June, 1982

June 11-13: *The Hurley Medical Center* will sponsor a conference on "Nonorganic Failure to Thrive: Theory, Research, and Intervention" at the Hyatt Regency Hotel in Flint, Michigan. Presentations, panel case discussions, and workshops will be addressed to a multi-disciplinary audience. Contact the Hurley Medical Center — 942, Continuing Medical Education, One Hurley Plaza, Flint, MI 48502, tel: (313) 766-0142.

June 28-30: *The SIDS Institute, Department of Pediatrics, University of Maryland School of Medicine* and *The Foundation for the Study of Infant Deaths* (United Kingdom) will co-sponsor a Sudden Infant Death Syndrome (SIDS) International Research Conference at the Hyatt Regency Hotel in Baltimore, Maryland. Address inquiries to Lois M. Roeder, SIDS Institute, 655 West Baltimore Street, Baltimore, MD 21201, tel: (301) 528-6911.

July, 1982

July 14-16: *La Leche League International* will sponsor its Annual Seminar on Breastfeeding for Physicians at the Riviera Hotel, Las Vegas. Write to Carol Kolar, Continuing Medical Education, La Leche League, Franklin Park, IL 60131.

July 21-23: *ASPO/Lamaze's 1982 Annual Convention* will take place at the Radisson Muehlebach Hotel in Kansas City, MO. Among other topics, educational sessions will consider MCH legislation, the family's role in adolescent parenthood, and new concerns in postnatal infant care. Contact ASPO/Lamaze, 1411 K St., N.W., Suite 200, Washington, D.C. 20005, tel: (202) 783-7050.

August, 1982

August 12-15: *The Eterna Internal Foundation* will sponsor the First International Conference on Pediatric Social Work, which will consider the topic "Current Controversies in Pediatric Social Work". Meetings will take place at the Radisson Hotel in Chicago, with special sections in child abuse, death and dying, adoption and foster placement, and genetic counseling. Write to the First Conference on Pediatric Social Work, P.O. 1344, Oakbrook, IL 60521.

October, 1982

October 20-24: The *Annual Meeting of the American Academy of Child Psychiatry* will take place at the Sheraton Washington Hotel in Washington, D.C. A pre-meeting *Institute on Infant Psychiatry* will focus on principles of assessment and intervention in the first years of life; faculty will include Klaus Minde, Justin Call, Henry

Massie, Eleanor Galenson, Elsie Broussard, and James Herzog. Contact the AACP at 1424 16th St., N.W., Suite 201A, Washington, D.C. 20036, tel: (202) 462-3754.

October 27-29: *The National Black Child Development Institute* will hold its 12th Annual Conference at the Los Angeles Hilton. The conference theme will be "Mobilizing for Black Children in a Time of Crisis." For more information write to Vicki Pinkston, NCBDI, 1463 Rhode Island Avenue, N.W. Washington, D.C. 20005, tel: (202) 387-1281.

March, 1983

March 29-April 1: *The World Association for Infant Psychiatry* will convene the Second World Congress on Infant Psychiatry in France to discuss "Infancy in a Changing World." For further information regarding membership in the Association and participation in the Second World Congress, contact Justin D. Call, M.D., Chief of Child and Adolescent Psychiatry Division, UCI Medical Center, 101 City Drive South, Orange, CA 92668.

PHOTO BY HOPE STEWART

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MULTIDIMENSIONAL STATISTICAL ANALYSIS: A PARTNER FOR CLINICAL INSIGHT

By Joseph Marcus, M.D. and Annie Aubrey, Ph.D.
Laboratory for Research Methodology in Child Development,
University of Chicago

Research in child psychiatry has gained increased attention in recent years as the field has responded to the challenge to develop more effective diagnostic and therapeutic methods. This paper describes an approach to research in child development and child psychiatry called **Facet Theory**, which provides (1) a way of conceptualizing highly complex studies, and (2) robust, non-metric methods of data analysis which we have found to be appropriate to the multidimensional data of child-development research (Shye, 1978; Lingoes, et al., 1979; Borg, 1981). Our use of these methods has been developed in the process of a long collaboration with Louis Guttman, Professor of Social and Psychological Assessment at Hebrew University in Jerusalem.

In 1978, the Unit for Research in Child Psychiatry and Development at the University of Chicago was asked to design and carry out a study of the long-term effects of methadone on the development of children born to women maintained on methadone. Most influences on development, whether drugs such as methadone or nicotine or environmental influences such as poverty or inadequate parenting, do not act in isolation as single factors, but only in combination with a host of other factors affecting development. We, therefore, wanted a design for our study that would reflect the complexity of actual development. Rather than using the classical experimental approach of isolating variables, we aimed at a design which would reflect "the

Henry Moore, Child Study.

FISCHER FINE ART LTD. LONDON

The Laboratory for Research Methodology in Child Development was established in October, 1981 by a grant from the Irving B. Harris Foundation. The immediate aims of the Laboratory are to develop and apply methodological tools appropriate to multivariate studies in child development. Its long-term goals are to integrate data from numbers of studies through the use of innovative methodologies, and to collaborate and consult with others doing longitudinal and multivariate studies.

The Senior Staff of the Laboratory, directed by Joseph Marcus, M.D., have both clinical and research training in a variety of areas of child development. Research staff includes Rita J. Jeremy, Ph.D., Sydney L. Hans, Ph.D., and Victor J. Bernstein, Ph.D. Statistical consultants are Louis Guttman, Ph.D., Hebrew University of Jerusalem, and Leland Wilkinson, Ph.D., University of Illinois at Chicago Circle.

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concurrent and interactive effects of multiple variables" (Sander, 1980). We conjectured that the effects of methadone on development might only show up in their interaction with other risk factors, whether genetic or environmental.

In order to assess the interactive effects of a number of variables, we needed a method of analysis which would display a **profile** of variables for individuals and subgroups. Since we wished to understand development over time, we also needed a method that would preserve information about individual paths of development.

Clinicians are accustomed to thinking about individuals, and about **syndromes** or patterns of symptoms. All mental health professionals recognize that heterogeneity is the hallmark of the human condition, and that although a group of individuals may suffer from the same clearly defined disease, they will differ in a number of ways—whether, biological, sociological, economic, or familial. Clinical judgments, whether made for the purpose of diagnosis or treatment, are the result of processing a great many symptoms and background factors at the same time. In designing our methadone study, we felt the need of analytical tools that would provide some of the richness of clinical judgments and case studies, and preserve the identity of individuals over time, yet allow statistical comparison of cases.

In at-risk populations, differences between the at-risk and comparison groups are usually due to a small subgroup—the one most likely to need treatment. Linear statistical models assume normal distributions, and these outlying subjects are generally considered a nuisance. Mathematical transformations are done to ensure that such subjects are brought closer to the center of the distribution. The usual methods of describing differences between groups—*t*-tests, analyses of variance, and discriminant analyses—provide information about differences in group means, but were not designed to describe individual subjects or subgroups of individuals.

Facet Theory—A New Approach

In our methadone study, we wished to answer a number of questions: would infants exposed to methadone *in utero* develop differently from comparison infants? would different systems be differentially affected? would the effects of methadone be mediated by other factors known to affect development? Facet Theory had proved fruitful in the study of the offspring of schizophrenics (Marcus, et al. 1981) and we thought it would be well-suited to the complexities of our long-term study of the effects of methadone.

Facet Theory makes use of two elements in its search for lawfulness—Facet Design, and multidimensional, non-linear techniques of data analysis.

Since objects and human activities are free to be classified in any number of ways, and the same object might be classified differently for the purposes of different scientific investigations, it is important to specify what **facets** of the object or activity in relation to what other facets are to be included in a particular study. For example, a sorting task on the Bayley examination which involves dropping blocks of various shapes and colors into a sorting box might be considered as a **cognitive** item, a **visual perception** item or a **motor** item in different studies. Facet design, using a tool known as a **mapping sentence**, makes explicit those facets of objects or behavior or phenomena that are relevant to a given empirical problem, and does this in a form that aids the perception of systematic relationships within the data. The mapping sentence provides a basis for writing hypotheses, and can be refined, expanded or contracted as necessary.

Non-metric, multidimensional methods of analysis are used to reveal patterns in a matrix of empirical data which might not otherwise be apparent, and to represent those patterns in the easily visualizable form of geometric models. Smallest Space Analysis (SSA) is a

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technique for looking at relationships among **variables**. Multidimensional Scalogram Analysis (MSA) and Partial Order Scalogram Analysis (POSA), a special case of MSA, are techniques for looking at relationships among the profiles of **individual subjects**, and are useful for identifying subgroups of individuals with distinct profiles. They can also be used to trace individual paths of development over time.

Using Facet Theory—Step by Step: The Mapping Sentence

In our study of the effects of methadone exposure *in utero* on the development of infants, we first used a **mapping sentence** to specify the outcome we were interested in—good to poor level of functioning for the development of the infant—and to help isolate those facets of variables which were relevant to this outcome. Figure 1 represents a highly simplified version of the mapping sentence for our methadone study (a more complete mapping sentence may be found in Marcus, Hans and Jeremy, 1982).

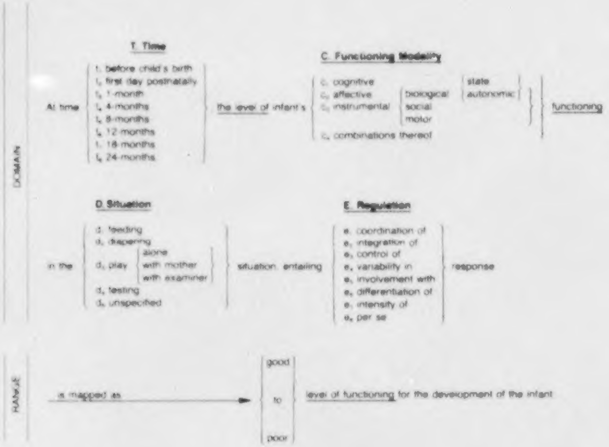
DOMAIN
T. Time
At time
t_1 before child's birth
t_2 first day postnatally
t_3 1-month
t_4 4-months
t_5 8-months
t_6 12-months
t_7 18-months
t_8 24-months
the level of infant's
C. Functioning Modality
c_1 cognitive
c_2 affective
c_3 instrumental
biological
social
motor
state
autonomic
c_4 combinations thereof
functioning
D. Situation
in the
d_1 feeding
d_2 diapering
d_3 play
alone
with mother
with examiner
d_4 testing
d_5 unspecified
situation entailing
E. Regulation
e_1 coordination of
e_2 integration of
e_3 control of
e_4 variability in
e_5 involvement with
e_6 differentiation of
e_7 intensity of
e_8 per se
response
RANGE
is mapped as
good
to
poor
level of functioning for the development of the infant

Figure 1: Brief Mapping Sentence of Infant Development.

The outcome of interest—level of functioning of the child—specified in the **range**—implies that any measure included in the study should have clear implications for the quality of child development. The **domain** of the mapping sentence sets forth stimuli, conditions and procedures that define a set of measures to be used in the study. Our core facet for the study of infant development is type of behavioral functioning (Facet C). We chose to conceptualize types of functioning by the classic trio of cognitive, affective and instrumental behavior. Instrumental behavior, in turn, includes 3 sub-parts: strictly motoric behaviors, social behaviors and biological behaviors, including both autonomic responses and the behaviors termed "state-control behaviors" by researchers in infancy.

We chose to include measures in our infant testing battery that would sample from each of these modalities of functioning. For example, we have included measures of infant attentional preferences (cognitive), responses to separation from mother (affective), walking (instrumental-motoric), clearness of communication with mother (instrumental-social), heart-rate responsivity (instrumental-autonomic), and consolability (instrumental-state control).

The mapping sentence makes the assumptions underlying an experimental design explicit. In doing so it serves a number of purposes. It provides a tool for assessing the relevance of particular variables to the study as a whole. The mapping sentence may identify variables that are relevant to the study, but not adequately represented in the assessment battery. For example, we found that no instrument existed for asssessing the **quality** of mother-infant interaction in everyday situations at a number of ages, and have spent considerable time developing such an instrument. Other instruments, such as the Brazelton Neonatal Behavioral Assessment Scale, measure too many aspects of development at once, and the mapping sentence provides a scheme for grouping overtly diverse items into meaningful scales before data analysis. A more usual method of grouping variables is to take items which are significantly correlated and, *post hoc*, to construct a theory for their relatedness. In any study with a large number of variables, correlations may occur that are merely statistical artifacts. *Post hoc* analyses can provide descriptive, but not explanatory, interpretations of data, and these descriptive explanations may then provide hypotheses which can be tested in additional studies. Facet design, on the other hand, posits an *a priori* relationship that should exist among variables. If this relationship is confirmed in the data, the conclusions may be regarded as strong findings.

Smallest Space Analysis

Given the *a priori* framework provided by our mapping sentence, we have, for example, grouped items from the Brazelton examination into cognitive, motor, and state categories rather than analyzing group means on each item separately, as is usually done on the results of the Brazelton. Our grouping of these items, in effect, constitutes an hypothesis that the items in each category are related more closely to each other than to the items in the other categories. Smallest Space Analysis (SSA) can be used to test this hypothesis about the relationships among variables. SSA refers to a group of computer programs for spatial analysis of data matrices, such as correlation matrices (Lingoes, 1979). SSA can handle large numbers of variables, and makes the structure of data easily visualizable in a geometric representation. Given a table of relationships among variables for a particular sample, such as a correlation matrix, the computer plots the variables in the smallest number of dimensions possible (hence, **smallest space**) that will preserve the rank order of the relationships. The more closely related variables are (that is, the higher their correlation), the more closely they will be plotted in space.

Distance between variables is one important aspect of an SSA map. **Regionality** is another. Variables are distributed into regions which are co-ordinate free (that is, one does not first draw reference axes, such as the common x and y axes). If there has been an *a priori* definition of facets, one can examine the map to see whether there are regions which represent the facets. For example, our prediction that items on the Brazelton exam would be structured as motor, state, or cognitive items can be tested by seeing if items in each of these three categories are more closely related to each other than to items in other categories, and fall into a common region. We did SSA's on correlation matrices of data at both one day and one month on 45 methadone and comparison infants from our methadone study. Both SSA's confirmed our *a priori* prediction with a few exceptions. Figure 2 shows the SSA for the one-day data.[1]

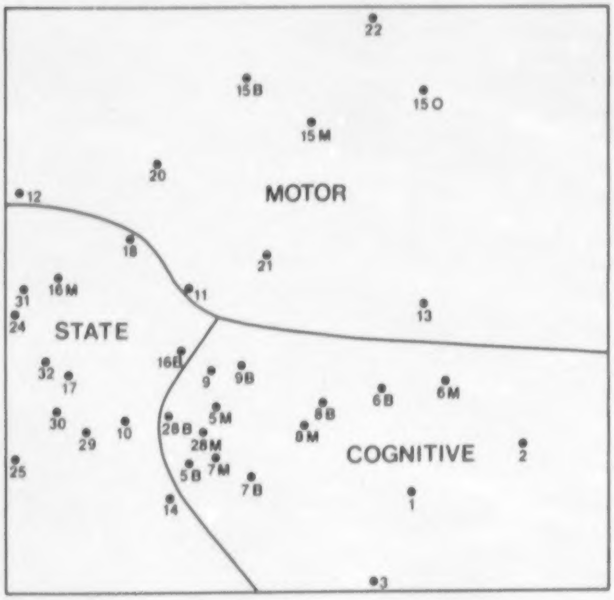

Figure 2: SSA of Brazelton Items.

NUMBERS REFER TO ITEM NUMBERS ON EXAMINATION
M = MODAL, B = BEST

Looking more closely at this SSA map, we can see that regions can be delineated which include motor, social and perceptual-cognitive items. As a visual aid, lines have been drawn around these regions, although the lines have no significance in themselves. Imagine for a moment that the items from each facet were scattered equally in all parts of the map. They would not, then, be able to be included within regions, and the hypothesis would not hold. Examine now the distance between items. Items which are most highly correlated, are, as we have said, closest to one another. In some cases, items from one region are closer to an item from another region than they are to items in the same region, and this requires some modification of the hypothesis. Item 10, for example, Alertness, a state item, is closer to many of the cognitive items than it is to many of the state items. The cognitive items to which alertness is closest, are, in fact, items which can only be administered in the most alert or active state. Other cognitive items, further away from Alertness, can be administered in a lower state of alertness.

Multidimensional Scalogram Analysis (MSA)

MSA is a technique for looking at relationships among subjects. It is useful for a research design in which information on each subject is collected on a number of variables or facets. Each subject can be defined by a **structuple** (Cartesian set) or a profile of scores on each variable. MSA creates a representation of these multivariate profiles in a geometrical space, plotting each profile as a point in this space so that there will be a clear partition of the space into regions according to the values of each variable, and so that each **individual**'s profile is plotted such that it is **closest** to the individual with the most similar profile, and **furthest away** from that individual whose profile is most dissimilar. POSAC is a special case of MSA in which the range of each variable is ordered in the same direction for each variable in the analysis. An example of MSA from our infant data on the Brazelton Neonatal Behavioral Assessment Scale with Kansas Supplements (NBAS-K) is presented below.

Figure 3 shows an MSA of motor and state functioning of 45 infants from our methadone study (20 methadone and 25 comparison infants) at one day. This MSA shows that methadone acts differentially on motor and state functioning (a further confirmation of our categorization of items), and identifies subgroups of methadone and comparison infants with different levels of functioning.

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[1] Readers who are accustomed to defining the relationships among variables by using Factor Analysis may be interested in the connection between Factor Analysis and SSA. Factor Analysis is the special or more restricted case of SSA, or as Guttman now terms it, Factor Analysis is an *extrinsic* model for which SSA is the *intrinsic* model (cluster analysis is another extrinsic model with other restrictions for which SSA is the intrinsic model). An intrinsic model that makes no *a priori* assumptions about the arrangement of the data and does not have mathematical restrictions or constrained parameters (non-parametric analysis) will, therefore, reveal something about the intrinsic structure of the data. An extrinsic model assumes certain structures in the data, and extrinsically imposes that structure on the data, or adjusts or corrects data to attain the best fit to defined parameters (parametric analysis). Common assumptions in such methods may include restrictions to known probability distributions, for example normal or random sampling or independence of observations. The precise mathematical differences between Factor Analysis and SSA are outlined in Guttman (1982, in press).

Individual profiles consisted of 5 items, 3 motor (General Tonus, Motor Maturity and Tremulousness), and 2 state (Alertness and General Irritability). Items were chosen on the basis of the facets in the overall design which had been confirmed in SSA. The MSA map shows two independent dimensions. The 3 motor items scaled in one direction and the 2 state items scaled in an orthogonal direction. Poor to good motor functioning is represented along the diagonal from the lower left to the upper right corner of the plot; at right angles to this diagonal, poor to good state functioning is represented from upper left to lower right along the other diagonal.

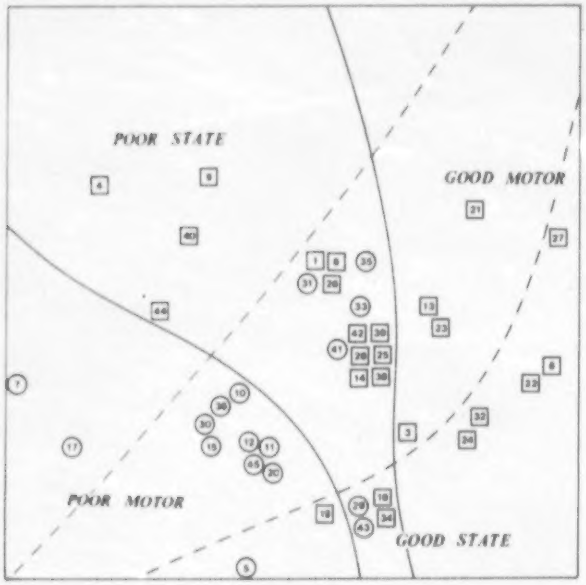

Figure 3: MSA of Brazelton Items at 1 day.

○ = METHADONE GROUP □ = COMPARISON GROUP

Curved lines are drawn as a visual aid to indicate the boundaries of the regions according to state or motor functioning. The profiles of those infants in the upper left corner (separated by a broken line) are characterized by poor state functioning—extreme irritability and poor alertness. Those in the lower left corner (separated by a solid line) are characterized by poor motor functioning—hypertonicity, jerky movements, and extreme tremulousness. There is an overlapping region in the middle left of infants with both poor motor and poor state functioning. Infants on the upper right side (separated by a solid line) are characterized by good motor functioning—moderate muscle tonus, smooth limb movements, and almost no tremors. Those on the lower right side (separated by a broken line) are characterized by good state functioning—low irritability and good alertness. The regions of the plot allow one to identify each infant by type of both motor and state functioning. For example, Infant #5 showed poor motor functioning with good state functioning; infant #34, good state functioning with moderate motor functioning.

In the region of both poor state and poor motor functioning there are only two infants—both exposed to methadone. In the region of both good state and good motor functioning, there are 5 infants, all non-methadone infants. Of the 12 infants showing poor motor functioning, 11 are methadone infants. Of the 9 infants showing good motor functioning, none are methadone infants. Thus, methadone infants can be clearly discriminated from non-methadone infants on the basis of motor functioning at one day of age, and it can be seen that methadone acts differentially on different functions, a fact not elucidated in previous analyses of such data using linear statistics. (See Marcus, Hans and Jeremy, 1982 for further discussion of these findings, and for a comparison with motor and state functioning of the same infants at 1 month of age.)

Replication

Careful construction of theory and design of content make generalizability and replication of findings possible, and this, in turn, makes possible the discovery of lawfulness. Although the search for this underlying lawfulness may be the rationale for social and behavioral science, inferential statistics, which are the most frequently used methods of data analysis in the social sciences, have serious limitations in leading to the discovery of laws in any empirical science (Guttman, 1977, Carver, 1978). More productive in moving toward this difficult goal have been methods of data analysis specifically appropriate to a substantive field, and careful definition of content. No laws in the physical sciences were ever established using random samples and inferential statistics. Laws have been verified by looking for patterns of correspondence between definitional systems and empirical observations.

Replication has meant to some social scientists the precise repetition of the same experiment under exactly the same conditions with exactly the same instruments used by observers who are trained in exactly the same way. Facet Theory provides a different approach to replication. The law of gravity has been tested and confirmed with a variety of objects of different weights dropped under a variety of conditions in a number of different places at different distances from sea level. Similarly, social scientists should be concerned with the testing and structural replication of laws, not of

In coming months, the Laboratory for Research Methodology in Child Development will make available computer programs and a user's manual for POSAC, SSA, and MSA. For further information, contact Sydney L. Hans, Ph.D., at the Unit for Research in Child Psychiatry and Development, Department of Psychiatry, University of Chicago, 950 East 59th Street, Box 411, Chicago, IL 60637, tel: (317) 947-1858.

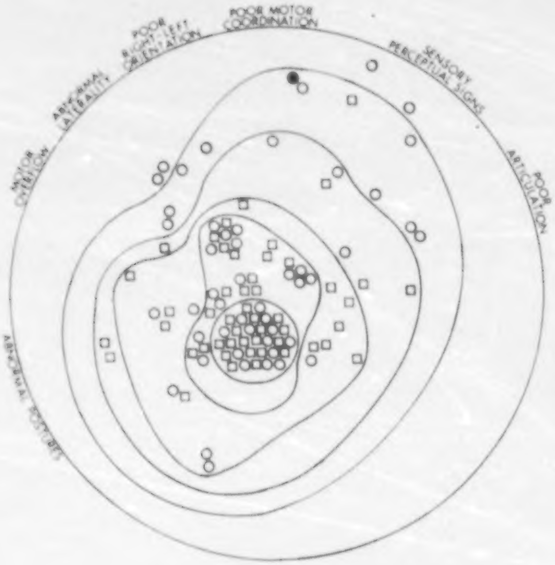

Figure 4: Multidimensional Scalogram Plot of Israeli 10-year olds.

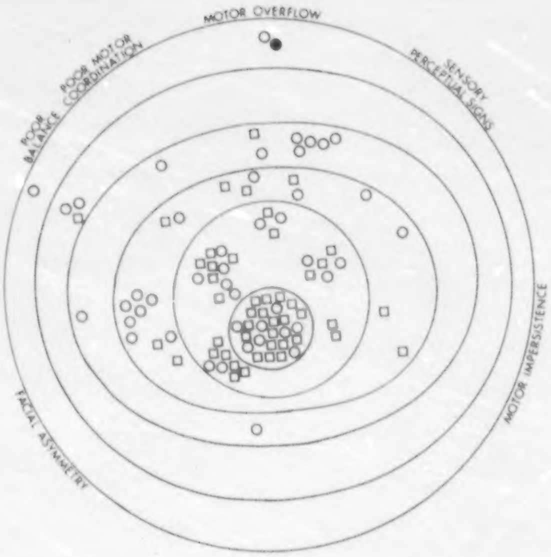

Figure 5: Multidimensional Scalogram Plot of Israeli 15-year olds' follow-up assessment

○ = OFFSPRING OF SCHIZOPHRENICS, □ = COMPARISON GROUP

experimental conditions, of the robust structural regularities that will persist even though subjects and experimental conditions vary widely.

For example, using SSA and MSA we have replicated patterns of neurological functioning in different samples of the offspring of schizophrenics (Marcus, Hans et al., in press). Figures 4 and 5 show MSA's of subjects in two studies of the offspring of schizophrenics, the first a study of neurological soft signs in 100 Israeli 10-year olds, half genetically at risk for schizophrenia. The second study was a neurological follow-up of these same children five years later using a different examination. Items on each examination were classified into 10 categories (or facets), and an SSA of the items in each study confirmed the validity of the *a priori* categorizations.

In each sample, sum scores were computed for each child for each category. MSA's were computed for each sample, using a profile of dichotomized sum scores for each child. In each sample, MSA produced a radex arrangement of subjects (i.e., an arrangement in which a linear ordering—distance from the center—is combined with a circular ordering—placement around a circle). In each MSA plot, subjects with the best neurological functioniong are located in the middle of the radex; those with the worst, in the outer rings. Subjects with the same level, but different types of neurological functioning are located in different areas of the same ring. The outer rings of each radex contain primarily offspring of schizophrenics; the inner rings, a mixture of offspring of schizophrenics and control group children.

The stability of this structure has been borne out so far in 2 further replications on data from Denmark (unpublished), and constitutes an unusual example of replication in behavioral research.

An additional use of MSA seen in this analysis is the tracing of an individual's functioning over time. Thus, of special interest in these two MSA's is the subject represented by the dark circle. This subject, now in her twenties, has actually experienced a psychotic breakdown.

Summary

The need to study individuals in all their complexity has led to a need for new tools of statistical analysis. We have found these tools in Guttman's Facet Theory, and they have allowed us in our own work to identify individual differences, identify subgroups with distinct profiles of functioning, differentiate specific rather than systemic effects on functioning, identify developmental patterns of individuals and subgroups over time, replicate findings and combine analyses of infant and maternal profiles. We believe these methods will be valuable to other clinicians who wish to preserve the sensitivity of clinical insight and, at the same time, satisfy the need for validation of their findings. Because Facet Theory relies less on specific instruments and more on their underlying facets, it should make collaboration among researchers easier.

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For Your Information:

"It is time for the United States to enter the twentieth century in the care of infants," declared **Ed Zigler** in a speech to the American Psychological Association on August 26. Zigler, Director of the Bush Center in Child Development and Social Policy at Yale and the first Director of the Office of Child Development in the Department of Health, Education and Welfare, has been a leader in the thirteen-year effort to enact federal standards for day care.

While public attention has focused primarily on the day care needs of pre-school children, Zigler is concerned about a new phenomenon: the fact that infant day care is the fastest growing form of day care in the United States, with placement of babies two months old and younger in day care becoming common.

With no longitudinal study in place that can hope to assess quickly the effects of infant day care, Zigler calls our present system a "high-risk gamble." Grossly inadequate care for infants may be widespread; Arizona regulations, for example, permit a single "adult" over the age of 16 to care for 10 infants. Yet high-quality care, provided by a skilled caregiver to three infants at a time, could cost from $3 to $5,000 per year per child. Zigler suggests that the best caretaker for a young baby is the child's parent.

To encourage parental care for infants, Zigler recommends the adoption of subsidized parental leave for mothers, fathers, or both—a policy already in place in most industrialized nations. Zigler is now forming a national committee to work toward this goal; those interested may write to him at the Department of Psychology, Box 11A Yale Station, New Haven, CT 06520.

The Rules Committee of the House of Representatives has unanimously approved H.R. 421, the resolution to create a Select Committee for Children, Youth and Families, and has cleared its way to be placed on the calendar for full House consideration. The 220 members of Congress supporting H.R. 421 hope for a full vote before adjournment.

The Illinois Ounce of Prevention Fund (see "For Your Information," **Zero to Three,** June, 1982) is a collaborative effort of the Illinois Department of Family Services and the Pittway Corporation Charitable Foundation. It aims to fund good primary prevention service programs in Illinois and to document effectiveness and cost-effectiveness of primary prevention efforts. Since June, the Fund has chosen an Executive Director, six grantees, an evaluation strategy, and an evaluation team.

Judith Musick, Ph.D., most recently director of an NIMH research and demonstration program, is now Executive Director of the Ounce of Prevention Fund. She is responsible for coordination of the six demonstration projects statewide and for working directly with the evaluation team.

The six programs selected in July for funding serve a variety of urban and rural and high-risk populations. All are research as well as service programs, and each will include parenting education, home visitors, supportive and self-help groups, individual counseling, advocacy, volunteers, services for teens, and interagency referral networks. In addition, some programs will have hospital or clinic-based prenatal, obstetrical, and well-child pediatric care.

A combined team of researchers from the University of Illinois School of Public Health and Northwestern University Center for Health Services and Policy Research is responsible for the Ounce of Prevention Fund evaluation. Representatives from the team assisted in the selection of service sites, and research staff will work together with service providers from the beginning of the program to develop and refine assessment procedures, to collect data, and to interpret findings.

For further information, write to Judith S. Musick, Ph.D., Ounce of Prevention Fund, Illinois Department of Children and Family Services, 160 North LaSalle, Room 1700, Chicago, IL 60601.

The cost of preventive and primary care for infants in New York state now can be covered by insurance. A new law requires those insurers and health service corporations that already provide medical, surgical, or major medical policies in the state to extend their

Continued on page 14

National Center Notes

by Eleanor S. Szanton

We who work with infants and their families operate in a wide range of settings. Yet as we share our observations, techniques, and research, we are developing a common awareness of those elements in a child's environment which are essential to healthy development in the earliest years. Our task, then, is to ensure that these elements are present wherever infants and families live or seek care—in the hospital nursery, the pediatrician's office, the home, the family center, the therapeutic facility, the day care center.

The National Center recognizes that more and more infants and toddlers are spending significant amounts of time in day care. Mothers of children under six are now the fastest growing segment of the labor force. Yet our concern for the quality of infants' day care experiences is not mirrored in the society at large. Care outside the home for infants and toddlers—whatever its quality—is hard to find. While some of the care available is outstanding, many day care centers serving infants and toddlers have group sizes and adult/child ratios larger than those suggested by proposed federal standards. In family day care, where infants and toddlers make up almost half the population, caregivers are largely unregulated, unsupervised, and unassisted. For too long there has been a sense within our society that pre-school caregivers should be teachers, while those "minding," "keeping," or "babysitting" infants and toddlers need few skills and very little training.

Extending the Child Development Associate (CDA) National Credentialing Program to those caring for infants and toddlers in centers and in family day care settings might help to change this situation. The CDA credentialing system was instituted in the early 1970's by the federal Office of Child Development, then directed by Edward Zigler, a current member of the NCCIP Board. The system allowed individuals working with three-to-five year old children in center-based programs to earn accreditation by demonstrating competency on the job to qualified observers, rather than simply by earning academic credits. The system was very carefully field-tested. Regulations of twenty-six states and the District of Columbia have included the CDA credential as one of the acceptable requirements for child care staff; ten additional states have included them in draft child care regulations. More than 10,000 teachers and caregivers now have CDA accreditation. Most important, the competencies have become a focus for academic, informal, and on-the-job training—a standard for quality care for three-to-five year olds.

In an effort to expand its scope, the CDA Credentialing Program developed drafts of competencies and assessment systems for home visitors and family day care providers in 1981 and for caregivers serving infants and toddlers, children with handicapping conditions, and bilingual children in 1982. An NCCIP work group has had the opportunity to participate in the development of competencies for those working with infants and toddlers, sharing our view of what constitutes a healthy environment for very young children.

The NCCIP material emphasizes the unique aspects of caring for children under three and the skills needed to foster appropriate growth at each stage of infant development. It focuses on the quality of the *relationship* between infant and caregiver as the most important catalyst to development at this age. It highlights the potential opportunities and problems connected with family day care, as distinct from center-based care. (A planned National Center paper on infants and toddlers in day care will draw heavily on this material).

Yet as these notes are written, the CDA system itself is facing radical changes in its current structure and possibly lengthy delays in its extension to new groups of caregivers. The Administration for Children, Youth and Families (ACYF), which has been supporting the CDA program, will soon be making a three year grant award designed to make the assessment and credentialing system completely independent of federal funding by 1985. No funds in the new grant are available for further development, testing, or dissemination of competencies for infant and toddler caregivers, although ACYF is encouraging interested groups to urge funding of such an effort by its parent organization, the Office of Human Development Services in the Department of Health and Human Services.

We see the effort to maintain the financial and professional integrity of the National CDA Credential and Assessment System and to extend the program to caregivers working with infants and toddlers as significant to all those who seek to promote optimal health and development of children in the earliest years of life. We will keep you informed as this effort continues.

We report with pride two awards recently presented to NCCIP Board members: **Kathryn Barnard** was awarded the 1982 Jessie M. Scott Award of the American Nurses Association, an award presented annually to an individual whose accomplishments in the field of nursing "bear witness to the interdependence of practice, education and research and their significance for the improvement of services to people and the vitality of the nursing profession." **Stanley Greenspan** received the 1982 Edward A. Strecker Award of the Institute of Pennsylvania Hospital for superior work in psychiatry. Greenspan's work was cited for "making a major impact on the ability of physicians to distinguish between normal and disturbed infant development as early as two to four months of age."

LEON J. YARROW: 1921-1982

Leon J. Yarrow died of a heart attack on July 28, 1982. He was 60 years old.

Lee Yarrow was Chief of the Child and Family Research Branch, National Institute of Child Health and Human Development. He had served as President of the Society for Research in Child Development from 1971-1973. A founder of the National Center for Clinical Infant Programs and a member of its Editorial Board, Lee was also a member of the Board of Directors of the National Easter Seal Research Foundation and on the editorial committees of several child development journals.

From his seminal contributions in the 1960's regarding maternal deprivation to his more recent interest and research in mastery motivation, finding new ways of understanding complexity in development has been a hallmark of Lee Yarrow's style and excellence.

Over many years, Lee was of enormous help to those of us who have been his colleagues. We always knew we could rely on his generosity, quiet wisdom, and clear thinking.

At Lee's memorial service, Judith Rubenstein, a close collaborator and, with Frank Pedersen, Lee's frequent co-author, shared the following thoughts. They express well what all of us feel.

"If you think back over the course of your life, I think you will find that there have been very few people outside your family who have made a difference—a difference, in terms of who you are, how you do your work, how you look at the world. For me, Lee Yarrow was one of those rare people.

I came to Lee's Child and Family Research Branch at NICHD in 1966. He let me take on as much responsibility as I could handle. He never said 'you're not ready for this' or 'you can't do that.' He was always there to help when I stumbled, but he never mentioned that I stumbled. He didn't let on that he noticed.

Lee had time for us whenever we wanted it. He was never too busy to talk. I had the feeling he must have worked around the clock to get done all that he got done and still always have time to talk. Many important people I know seem so busy, so unapproachable. They should have watched him, if they had had the opportunity. They would have learned something.

Lee had a marvelous way of telling the truth, the painful truth, so that it didn't hurt. I once wrote a paper that was really awful, and Lee let me know that it was awful without making me feel that *I* was awful. Later, when he said a paper I had written was good, I believed him.

Lee thought in terms that eluded most of us. He asked larger questions, about what things meant, about meanings that seemed self-evident until he posed the question. Maternal deprivation—to take an example familiar to most of you—what does it mean? Before Lee wrote about it, it was a vague, ill-defined concept that helped explain marasmus in institutions. After he wrote about it, the field of infant research was reorganized. Probably five thousand graduate students researched maternal deprivation and five thousand more careers were built studying mother-infant interaction in the light of Lee's ideas. (Perhaps five thousand is an exaggeration—perhaps it just seems that way to me. But that is a measure of man's impact, isn't it?)

It was a foregone conclusion in the Branch when I was there that Lee's intellect was something unique. We would have a research meeting at which I, or someone else, would state the research problem. We would be quite satisfied with the way we framed the question. Then Lee would quietly, gently reconceptualize it so that it was much better, much deeper, much more thoughtful. And we would leave the meeting chuckling—he had done it again.

Lee was interested in everything—I could never understand how he could attend a lecture on immunology in the pediatrics department, or a talk on the mechanics of some computer in the engineering department, or a lecture on the biochemistry of some rare enzyme in the medical department, and ask intelligent questions. Many people went to those lectures out of politeness. Lee went to learn.

Lee taught us to ask the tough questions—and not expect them to be answered easily. No quick experiment to find a rush answer. No rush into print. Ask the question that interests you, and do what needs to be done to find the answer. If it takes two years of careful observation to find the answer, then two years it is. No short cuts, no easy path to find what is meaningful.

I've never done this before. I've never spoken at a memorial service. Lee is doing in death what he did in life—encourage us to try what we have never tried, to expand our horizons, to grow—to develop what we only half thought about developing, to be what we might be, if only we dare.

Is there any more one can do for a friend?"

Case Report:

REMOVING OBSTACLES TO ATTACHMENT: INFANT-PARENT PSYCHOTHERAPY WITH AN ADOLESCENT MOTHER AND HER BABY

by Barbara Kalmanson, M.A. and Alicia F. Lieberman, Ph.D.
Infant-Parent Program, San Francisco General Hospital

The following case is an example of infant-parent psychotherapy (Fraiberg, 1980) with a poor, black, adolescent mother and her newborn baby. The case illustrates two important clinical issues in a high risk situation. First, it shows that the methods of infant-parent psychotherapy can be beneficial even in the face of chaotic socioeconomic conditions when insight-oriented intervention is used in conjunction both with assistance around the concrete problems of living and with developmental guidance on child rearing. Second, it demonstrates the importance of a careful assessment of the mother's affective investment in her infant and of the mother-infant interaction as primary indices in making a clinical decision about the potential usefulness of treatment. In our experience, the nature of the mother's tie to the baby tends to override other weighty prognostic considerations, such as maternal history and the existence or absence of a supportive network of family and friends.

The sheer number of stressors in this mother's current circumstances and in her past suggested a grim outlook for the budding relationship between herself and her infant. Wendy, the mother, had been abandoned shortly before delivery by her boyfriend, the baby's father. Wendy herself had been ambivalent towards this unplanned pregnancy. She had originally planned an abortion but at the last moment felt unable to go through with it. She opted instead to give the baby up for adoption, only to discover three days after delivery that she was also unable to follow through with this plan. Family pressure played some role in her decision to keep the baby: the childless aunt and uncle with whom she lived openly encouraged her to keep him.

This was not Wendy's first experience with pregnancy and childbirth. Though just nineteen, she had been pregnant twice before. The first pregnancy was terminated by an abortion. The second time Wendy gave the baby up for adoption. These facts, compounded by Wendy's difficult struggle in deciding to keep the present baby, her overtly expressed ambivalence towards being a mother, and her fears that she would not know how to care for a baby, alerted the social worker at the newborn nursery about the potential for disturbances in this mother-infant relationship. She suggested the Infant-Parent Program as an appropriate place where Wendy could talk to somebody "who knew about mothers and babies and the problems that can come between them." Wendy agreed to the referral.

The Infant-Parent Program

The Infant-Parent Program is located at the San Francisco General Hospital, which serves a predominantly low income, multi-ethnic, inner city population. The program provides a range of infant mental health services to the Department of Pediatrics and to community agencies—from clinical consultation, assessment and treatment to professional training and dissemination of knowledge about infant mental health. The core of the program involves assessment and intervention with infants and families where marked disturbances of attachment endanger the infant's normal developmental progress. Due to the program's physical location in the hospital and our close collaboration with the Department of Pediatrics, we can be immediately available in those settings where high risk situations for infants are most likely to be discovered: the newborn nursery and the well-baby clinic. This coordination of pediatric and infant mental health services enabled us, in the case of Wendy and her baby, James, to begin our intervention in the first week of the baby's life.

The first step in our intervention is an assessment consisting of 5-7 weekly sessions which take place mostly in the home. The sessions are designed to observe the physical environment and to gather information about the parents' concerns, life history, their perspective on themselves as individuals and as parents, and their interaction with their baby. A videotaped developmental assessment and free play sequence between parents and baby take place in our office playroom.

The first assessment visit with Wendy and her baby took place in her aunt's house, where Wendy was staying temporarily and where she slept on the living room couch. The baby had a small crib placed beside the couch. Wendy's 13 year-old brother was also staying in the same room and slept on the floor in the corner.

"Where I'm Staying At"

Wendy's past seemed as unstable and overcrowded as her present situation. She described herself as growing up poor, black, a member of a large family who was locked into the welfare system and whose members were in constant conflict with the law. Wendy's living conditions were often unpredictable. She and her siblings were sent to live with relatives for varying periods of time; she had several step-fathers; her brothers intermittently lived in group homes or correctional institutions. Her mother continually moved back and forth between Los Angeles and San Francisco, more often than not leaving the children behind in a

Mother and 11 day old infant, Bahamas. BARBARA YOUNG

variety of places. Wendy's reference to her living situation as "where I'm staying at" reflected more than dialect: it was a compelling reality. Combined with the impermanence of the physical environment was an impermanence of relationships. Wendy had grown up always disappointed in the expectation that the important people in her life would protect her and take care of her. It was not surprising that she doubted her own ability to protect and take care of her baby.

We ourselves thought that Wendy's capacity to care for her infant was an open question, and we wondered about the course of action that would best promote James' welfare: whether to facilitate the baby's relinquishment by siding with that part of Wendy that feared being encumbered by the baby, or to facilitate the growth of the attachment between mother and infant by exploring and attempting to remove the intrapsychic obstacles that were interfering with its development.

We observed the mother-infant interaction for cues about the most appropriate course of action. A very worrisome observation was Wendy's attribution of malevolent motives to the baby. In these attributions, James seemed to become his father's representative in Wendy's eyes. "He's trouble," she commented once as she watched James sleep. "My girlfriend said he's going to be trouble for girls when he grows up." She then said that she wanted him to be "sweet and nice, and not be hard on women like his father." As if to illustrate her own role as victim, Wendy said, as she carried James in her arms and the baby's fingers touched her face: "Bam! There he goes again! Sometimes he scratches me when he wants to eat. I know he knows it hurts me. He knows I feel it because I say 'ouch'." James was just like his father, trouble, and just like his father he was hurting her. We feared that as James became more active and autonomous, and as he understood his mother's comments about his behavior, these attributions would become increasingly detrimental to his development and might even create a self-fulfilling prophecy.

While worried about these attributions of malevolence to a 2-week old baby and concerned about Wendy's history and current unstable circumstances, we also looked for positive signs of Wendy's affective involvement in her baby, and found them. She stayed close to James throughout the sessions, keeping an affectionate eye on him as he slept. Even in the midst of recalling painful past experiences, Wendy could mobilize herself to respond to James quickly and appropriately. She was often attentive, gentle and responsive. And, importantly, she wanted to be a good mother for her baby, and wanted our help in achieving this goal.

Wendy expressed resentment for her aunt's intrusiveness in giving her childrearing advice, yet was aware of her own uncertainty in making decisions about James' care. She worried endlessly about her capacity to be a good mother, and wanted to feel more self-assured. The therapist offered to meet with her monthly for as long as both agreed the meetings were useful. The schedule of once a month was chosen in response to our sense that James was not in danger in Wendy's care and that Wendy needed to experience her own autonomy as an adolescent attempting to become an adult.

Treatment Unfolds

As the treatment unfolded, two major areas of psychological work emerged. First, Wendy needed to develop a solid identity as a mother. Second, she needed assistance in disentangling her baby from her enactment of the past in the present. The environment presented its own problems. Wendy needed her own place to live because she felt unwelcome and exploited at her aunt's house.

How to find a place, where to live, and who to live with were constant sources of anxiety. On the other hand, she showed remarkable resourcefulness in securing funds for adequate food and clothing for herself and James.

By providing occasional assistance with practical issues, particularly housing, the therapist cleared the way to focus on the psychological issues. Wendy's experiences as a mother were fraught with painful memories about her own mother. She regretted that she had to be alone during the delivery. She had hoped that her mother would be with her when the baby was born, but her mother stayed with her brother in another city in order to help him get out of a correctional home. Bitterly, Wendy said: "My mother's always been there for my brothers, but not for me. I have these pictures of James for her and I don't even have her address to send her one." The therapist sympathized with the depth of her disappointment, adding that Wendy wanted something different for her sone and herself but she worried that she could not provide it. As Wendy nodded sadly in agreement, the therapist commented that whenever Wendy made a decision about how to care for her child, she worried that she was wrong. The therapist then asked her how it was that her ordinarily fine judgment could be so easily shaken. Could it be that although she knew was doing just fine, a little voice inside, perhaps from somewhere else, maybe from her own childhood, made her wonder if she had done something wrong? Wendy had not thought about the voice before, but she recognized that critical voice inside her as her own mother's voice.

Wendy was much relieved by the realization that the "critical voice inside her" was not an objective appraisal of her mothering skills but represented an identification with her critical, withholding mother. This insight also led her into further self-exploration. In subsequent sessions she began to worry about how her own childhood might affect her. In one session, she wondered about the "hereditary nature" of child abuse. Her biological explanation suggested that she imagined the conditions were fixed, that she would be unable to change them. Responding to this implicit message, the therapist asked about the reasons for Wendy's interest in child abuse. As James slept, Wendy talked about how frightened she felt as a child when her mother was drunk and angry. Her mother kicked, punched and threw furniture at the children. She locked them in the house not allowing them to go to school when they were bruised. With tears on her cheeks, Wendy described a scene from her childhood. Her mother had broken plates and glasses on her head because Wendy had overcooked the bacon. "I can feel it now," she said as she patted her hair gently, "We were pulling pieces of glass out of my head for weeks."

Identification with the Aggressor

James woke up crying as she talked. Wendy quickly shifted her attention to him, changed his diaper, and then began to feed him. But she used a new feeding technique, one that the therapist had never seen her use before: she propped the bottle up on a pillow next to him on the bed. When James fussed in protest at this unusual arrangement, the therapist asked Wendy what she imagined he wanted. Without hesitating Wendy explained that she had a new goal for James: she wanted him to learn to hold his own bottle at four months of age. We explored the origins of this new goal. The therapist commented that on other occasions James had given her many signals when he was ready for something new. What did Wendy think he was signaling now? Wendy acknowledged that he wanted to be held, but, unlike other occasions, she could not bring herself to hold him as he fed. She persisted in propping the bottle, putting some distance between herself and her child.

We hypothesized that the memory of having been abused had awakened in Wendy a powerful identification with the aggressor (her own mother), and a concomitant fear that she (like her mother) would abuse her own child. In physically distancing herself from her baby and encouraging him to hold his own bottle, Wendy was attempting to protect him from her own aggressive impulses.

The dynamics of Wendy's use of physical distancing as a way of protecting the baby against possible abuse were painstakingly explored in the course of many sessions. Wendy could acknowledge the experience of anger towards her baby, and was relieved to find that her fear of abusing the baby was in fact an indication that she fully intended to protect the baby from her anger. By siding with her ego against the dangerous impulse to hurt him, and by helping her recall her helplessness and anger at her mother when she herself was being abused, we enabled Wendy to redirect the anger that was displaced to the baby back to its original target: her own abusing mother.

As Wendy came to realize that the perceived threats to her well-being originated not in James but in her own mother, the malevolent attributions to the baby declined dramatically. The focus of the therapeutic work then led back to the second cause for concern: Wendy's unrealistic self-doubts about her competence as a mother. The intensity and pervasiveness of these conflicts reflected more than the usual adolescent uncertainty and self-scrutiny on the road to adulthood. We speculated that these conflicts were deeply rooted in Wendy's early experiences. Wendy had been able to identify the critical voice inside her as an introjection of her mother's persistent nagging and dissatisfaction. This insight had in turn led to memories of being abused by her mother. But the self-doubts remained, although the attributions of malevolent motives to James had declined. We patiently waited for more childhood memories to emerge, while continuing to provide emotional support and developmental guidance in the course of many sessions.

The "Ghost in the Nursery"

When James was 13 months old, the "ghost" in his nursery emerged (Fraiberg, et al., 1975) in the course of a very poignant session. Quite suddenly, Wendy announced that she had decided to have a tubal litigation because she never wanted to be pregnant again (she was now 20 years old). Simultaneously, she expressed concerns about James' health: she worried about sudden infant death syndrome, thought a mild cold could develop into something serious, and followed every one of James' movements about the room with a vigilant eye, fearing he would put a dangerous object in his mouth. In the course of this session Wendy alluded to her little sister for the first time. The therapist noticed Wendy stiffen at the mention of this sister. When she asked about her and where she was, Wendy answered by giving the name of the cemetery. Wendy then related the gruesome tale of finding her 15 month old sister in the bathroom—brown foam spewing from her mouth, a can of cleanser on the floor next to the baby. Mother and baby rushed to the hospital leaving Wendy behind, never to see her sister alive again. There was no explanation to Wendy about her sister's sudden disappearance. Now, years later, Wendy could recall the event in vivid detail. She also remembered a dream she had had before the accident; perhaps it was a premonition, she mused. In her dream, the baby was frozen, and everyone in the family tried to "unfreeze" her in vain. Her memory shifted abruptly back to the funeral—her aunt had encouraged her to go to the coffin and kiss her baby sister goodbye. She did not want to kiss her sister. She was afraid that if she did so, she might resurrect her.

Hidden behind Wendy's sudden desire to have a tubal ligation and her preoccupation with James' health and safety was the mounting anxiety she experienced as James became increasingly mobile and approached the age when her sister died. As she recounted the horrible memory, she was consciously aware of her continuing fear as a child that she might "do something wrong" whether at the funeral, helping her mother, or with the neighbors. She realized this fear of wrongdoing had been a concern ever since. Once she recognized this fear of wrongdoing (that she had forseen the baby's death, perhaps wished it, perhaps caused it) she was able to understand that her unrealistic self doubts about her competence as a mother today grew out of her childhood fears and fantasies about her role in her sister's death.

During the next three months, Wendy was overly vigilant in tracking James' every move, though she now understood why. She was no longer preoccupied with the imminent disaster that might befall him, and she put aside further thought about a tubal ligation. Wendy celebrated James' 15 month birthday with tremendous relief. We celebrated for him, and also for her unencumbered confidence as a mother.

The capacity for insight in this poor, black, teenage mother, combined with her strong personal resources and her clear desire to invest herself in her baby, allowed her to use infant-parent psychotherapy to protect her child from the multitude of psychological and environmental risks to his healthy development. Despite the multitude of risks that were present in the first weeks of his life, this mother's affective investment in her baby proved to be the best prognostic indicator of successful treatment. Through her monthly contacts with the therapist, Wendy was able to experience a supportive and consistent relationship which she could use to understand some of the feelings from the past that invaded her relationship with her baby. By providing a preventive intervention, one that started in the first weeks of the baby's life, we were able to ensure that the relationship between mother and baby was protected and could develop positively. In addition, this allowed the baby to develop appropriately. At 18 months, James performed at least two months ahead of his chronological age in all areas on a developmental testing. He is currently a bright-eyed, alert, competent, inquisitive child, pleased to relate to people and clearly preferentially attached to his mother.

References:

Fraiberg, Selma, editor, *Clinical Studies in Infant Mental Health* (New York; Basic Books, 1980).

Fraiberg, S., Adelson, E, and Shapiro, V., "Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships." *Journal of the American Academy of Child Psychiatry*, 1975, 14, 387-421.

coverage to include preventive and primary care services for infants from birth to one year of age.

The law defines preventive and primary care services as including "a predetermined number of well-child visits to a physician and an initial hospital checkup; screening and early detection services supervised and performed by a physician; and routine and necessary immunizations."

Six Congressional Science Fellowships in Child Development will be awarded by the Society for Research in Child Development and the American Association for the Advancement of Science in 1983-4. Fellows work on the staffs of individual Senators and Representatives or on the staffs of Congressional committees. They participate in a one-month orientation and placement program and a year long educational program. Applications are due November 15. Those interested in applying should write for more detailed information to: Dr. Barbara A. Everett, Director, Washington Liaison Office, SRCD, 100 North Carolina Avenue, S.E., Suite 1, Washington, D.C. 20003, tel: (202) 543-9582.

"I don't think a Secretary of Agriculture ought to have any excuse. Let him wash the blood off his own hands and get it done. This is a very heartrending allegation here."

The speaker was Judge Charles R. Richey of the United States District Court in Washington, D.C. The occasion was Richey's August 27 order to the U.S. Department of Agriculture to reallocate "immediately" some $7-12 million of the Women, Infants and Children (WIC) supplementary food program from states that had not spent available funds to states that needed additional money. When the Justice Department lawyer arguing on behalf of the Agriculture Department offered to start distributing the unspent money after the current fiscal year ends September 30, asserting that a wait of five to six weeks would do no harm, Judge Richey replied that by that time some of the unserved children might be dead or retarded.

The lawsuit before Richey was filed by the Food Research and Action Center (FRAC) and the Georgia Legal Services Program, joined by the New York State Health Commissioner and three Democratic Congressmen. The suit charged that nearly 50,000 participants had been dropped from WIC programs in Georgia and New York because of a lack of funds, although other states had not spent all of their WIC funds and Congress had mandated that the excess be reallocated.

About 2.2 million women and children are served annually by the WIC program. Participants must meet income criteria for eligibility and must also be "at nutritional risk" in order to receive high-protein, high-vitamin foods. A FRAC spokesperson estimated that some 8 million women and children meet these criteria nationwide, although the $1 billion annual budget is sufficient to serve only slightly more than one-fourth of this group.

The Food Research and Action Center will continue to monitor the WIC program and plans to set up a WIC network of health professionals, state coordinators, advocates, and participants. Contact FRAC at 1319 F St., N.W., Suite 500, Washington, D.C. 20004, tel: (202) 393-5060.

Anticipating an estimated $800,000 in Fiscal Year 1983 to support up to four awards, the National Institute of Mental Health is now accepting applications for Preventive Intervention Research Centers (PIRCs). A special research grant announcement issued in April states that "the basic purpose of the PIRCs program is to support the development and maintenace of a productive reserach environment, in a clinical, academic, or community setting, or an appropriate collaborative relationship between two or more such settings. Behavioral and clinical research scientists, clinicians, and prevention specialists can interact in such an environment and conduct high quality research on problems concerned with early interventions aimed at the prevention of mental illness, significant psychological dysfunctin, and/or emotional disturbance among populations at risk."

There is no prescribed model for Preventive Intervention Research Centers. Potential applicants may receive consultation by contacting Juan Ramos, Ph.D., Director, Division of Special Mental Health Programs, NIMH, 5600 Fishers Lane - Room 18-105, Rockville, MD 20857, tel: (301) 443-3533.

Courses:

Bank Street: The Graduate School of Education at Bank Street College in New York City is offering a number of weekend courses this fall. Among them are a basic course in the theory and practice of parenting groups (December 10,11); an advanced practicum in parenting group leadership (November 5,6); and a seminar in the role of corporations in child care service delivery (December 3,4). For further information, contact the Office of Admissions, Graduate School of Education, Bank Street College, 610 West 112th Street, New York, N.Y. 10025, tel: (212) 663-7200, x 313.

Harvard Medical School: The Child Development Unit of the Children's Hospital Medical Center, affiliated with Harvard University Medical School, will offer a course on "Behavioral Assessment of Newborns and Older Infants" directed by T. Berry Brazelton and Michael W. Yogman. The course will be given in Boston twice during the fall and winter, on November 3-5, 1982 and February 2-4, 1983. Contact Edward P. Gelb, Child Development Unit, 333 Longwood Avenue, Boston, MA 02115, tel: (617) 735-6948.

Conference Call:

October, 1982

October 7-8: *The Menninger Foundation* will sponsor a workshop entitled "Infant Psychiatry: The Growing Edge" in Topeka, Kansas. Albert Solnit, Howard Osofsky, Joy Osofsky and Howard Fox will be featured speakers. Panel discussions on Infant Custody in Divorce, Infant Placement, and Intervention Programs in Infancy will be also offered. For information, contact June Mikulka, Division of Continuing Education, the Menninger Foundation, Box 829, Topeka, KS 66601, tel: (913) 234-9566.

October 20-24: *The American Academy of Child Psychiatry* will hold its 29th annual meeting at the Sheraton-Washington Hotel in Washington, D.C. A one-day institute on "Infant Psychiatry: Principles of Assessment and Intervention in the First Year of Life," scheduled for October 20, will include Robert Harmon, Klaus Minde, Justin Call, Henry Massie, Eleanor Galenson, Elsie Broussard, James Herzog, Robert Tyson and Peter Blos, Jr. as faculty. The meeting's main scientific program will include a panel on "Developmental Approaches to the Diagnosis and Treatment of Psychopathology in Infants and Young Children: A Preventive Intervention Model," presented by staff of the Mental Health Study Center, NIMH; a panel on "Assessment of Primary Preventive Interventions" with Elsie Broussard and John Kennell; and paper sessions on infant psychiatry and parenting of infants and toddlers. For information contact the AACP, 1424 16th St., N.W., #201A, Washington, D.C. 20036, tel: (202) 462-3754.

October 23-28: *The American Academy of Pediatrics* will hold its annual meeting in New York, New York. Sally Provence will conduct a round table on "Development in the Early Years: Practical Application of Clinical and Research Data." Michael Yogman will lead a round table on "The Father's Role in Infancy." George Peckham and William Fox will present a seminar on "Current Concepts in Perinatal Pediatrics;" a section scientific meeting on "Promoting Breastfeeding: The Community-Wide Challenge" will also be featured. For information, contact the American Academy of Pediatrics, Box 1034, Evanston, IL 60204.

November, 1982

November 11-14: *The National Association for the Education of Young Children* will hold its annual conference in Washington, D.C. The Family Resource Coalition has planned a preconference session on November 11 to discuss "Family Matters—Private and Public Sector Responses to Families' Needs. Conference sessions, grouped according to general areas of interest, include offerings on child advocacy, child care, child development, infants/toddlers, parents, and research. For information, contact NAEYC, 1834 Connecticut Avenue, N.W., Washington, D.C. 20009, tel: (202) 237-8777, or 800-424-2460 toll free.

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November 11-14: The Annual Meeting of the *American Association of Psychiatric Services for Children* will take place at the Hyatt Regency in Houston, Texas. The theme of the meeting is "Violence and Abuse: Clinical, Research, and Service Implications." A study group on infancy, open to interested AAPSC members, will take place on November 11. For more information, write the AAPSC, 1725 K Street, N.W., Suite 1112, Washington, D.C. 20006.

November 20: *The Infant Mental Health Association of the Delaware Valley* and the *Child Development Center, Alfred E. DuPont Institute,* will co-sponsor an interdiscplinary symposium entitled "Infants Born at Risk: Optimizing Affective Developmental Outcomes." The meeting will include panels and workshops and will be held at the Institute in Wilmington, Delaware. For further information, contact Bernard J. Schuman, M.D., Center for the Urban Child, 112 North Broad Street, Philadelphia, PA 19102, tel. (215) 972-0926.

November 20-21: *The American Psychoanalytic Association* will hold its seventh Workshop for Mental Health Professionals at the Hotel Roosevelt in New York City. The topic is "The Relevance of Infant Observational Research for Clinical Work with Children, Adolescents and Adults." Samuel Abrams, Charles Brenner, Arnold Cooper, Selma Kramer, Joseph Lichtenberg, James McLaughlin, Robert Michels, Peter Neubauer, Samuel Ritvo, Arnold Rothstein, Albert Solnit, and Daniel Stern will participate in the three panels and small discussion groups. Write to Dr. Arnold Rothstein, Chairman, Workshop for Mental Health Professionals, American Psychoanalytic Association, 1 East 57th Street, New York, N.Y. 10022 for further information.

December, 1982

December 13-16: *The U.S. Office of Special Education Programs* and the *Council for Exceptional Children* will co-sponsor the 1982 annual Handicapped Children's Early Education Programs Division on Early Childhood Conference, to be held at the Sheraton Washington Hotel, Washington, D.C. The program will focus on infant assessment and intervention, strategies for working with families, services to handicapped pre-school children, and the efficacy of early intervention. For information, write to Mary D. Laney, Conference Liaison, Department of Psychology, University of South Carolina, Columbia, SC 29208.

December 15-19: The fall meeting of the *American Psychoanalytic Association* will be held at the Waldorf-Astoria Hotel in New York City. The "Meet-the-Author" program will feature Stanley Greenspan, discussing his book "Psychopathology and Adaptation in Infancy and Early Childhood: Principles of Clinical Diagnosis and Preventive Intervention" (Clinical Infant Report #1) in a three-hour question and answer session.

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